DOES THE DEVELOPMENT OF COUNTERTRANSFERENCE AWARENESS INFLUENCE THE THERAPEUTIC RELATIONSHIP? A GROUNDED THEORY ANALYSIS

SHELLEY GAIT

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Department of Health and Social Sciences and Applied Sciences, University of the West of England, Bristol

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ABSTRACT

The psychodynamic literature suggests that countertransference is an inevitable part of therapy and a significant feature of the client-therapist relationship. However, countertransference is also considered to be a 'double edged sword'; when it is reflected on by the therapist, it can offer valuable insights into the therapeutic relationship, but when it remains outside of awareness and therefore unmanaged, it can result in the therapist unwittingly acting out in the therapeutic relationship and responding in counter-therapeutic ways. While research into countertransference currently lags behind the voluminous theoretical literature on the construct, in recent times there has been a growing interest into countertransference management. While some key factors in this process have been identified, how awareness of countertransference develops has yet to be explored. The purpose of this research was twofold, to explore the development of countertransference awareness and how this may or may not influence the therapeutic relationship and to construct a grounded theory of the process. 15 qualified therapists were recruited and interviewed, either, face to face or via Skype, using a semi-structured interview. The grounded theory constructed from the data suggests that participants initially experienced countertransference as threatening and overwhelming. When the experience of overwhelm was contained in supervision and therapy, the work context and by their theoretical framework, participants could reflect on their countertransferential responses, make sense of their experience, which developed their self-awareness and other insights, to the benefit of the therapeutic relationship. Conversely, a lack of containment in these domains, resulted in participants acting out their countertransference and becoming either over or under available in the therapeutic relationship. Implications for practice, supervision and training are discussed, with recommendations for practice. In addition, avenues for further research are also explored.

INTRODUCTION

The constructs of transference and countertransference, originally developed by Freud (1910, 1912, 1959), the founder of psychoanalysis, are one of the most 'durable' theories of human interpersonal relations within the field of psychoanalysis and psychotherapy (Levy & Scale, 2012). Transference, according to Freud, occurred when the client transferred strong feelings onto the analyst, which were rooted in the client's interpersonal relationships from their past. In his early writings, Freud, considered the transference a hindrance to the analytical endeavour, however, he later revised this view and argued that the identification and interpretation of the client's transference, was central to the work of analysis. Countertransference was understood by Freud to be the analyst's transference to the client, which Freud believed could result in an emotional entanglement, with the analyst acting out in counter-therapeutic ways. Consequently, Freud argued countertransference should be removed from the analysis at all costs. While Freud revised is understanding of transference, in his view, countertransference remained an obstacle in the therapeutic endeavour.

Today within the psychodynamic literature, while it is generally agreed that countertransference, broadly defined as the therapist's emotional response to the client, is an inevitable and central part of therapy, which, when left unmanaged, can result in a negative therapeutic outcome, such as the therapist acting out towards the client (Burwell-Pender & Halinski, 2008; Casement, 1985; Coren, 2015; Gabbard, 2001; Gelso & Hayes, 2007; Hayes 2004; Ligie & Gelso, 2002; Marroda, 2004; Pope, Greene & Sonne, 2006; Rosenberger & Hayes, 2002; Rowan & Jacobs 2002; Stark 2000, Zachrisson, 2009). Conversely, it is now agreed, that if countertransference is reflected on and managed, it can benefit clinical work, by illuminating both the client's and the therapist's interpersonal dynamics. Countertransferential material is, therefore, considered an important part of therapy, which requires of the therapist both awareness and the motivation to examine and work through these feelings as they arise (Burwell-Pender & Halinski, 2008).

Critique of countertransference research

While there has been substantial theoretical and clinical interest into the construct of countertransference, empirical research in the area has been relatively sparse (Hayes, 2004). According to some researchers and authors (e.g. Fauth, 2006; Friedman & Gelso, 2000; Gelso & Hayes, 2007; Hayes, 2004; Najavities, 2000; Pope Greene & Sonne, 2006), there has been a reluctance within the school of psychoanalysis to engage in empirical research of any kind due to stark differences in epistemological values between practitioners and scientists. This has resulted in a research lag, with much of the theoretical literature focusing on debating the elements which constitute the construct (Fauth, 2006; Hayes, 2004). According to several authors (e.g. Fauth, 2006; Friedman & Gelso, 2000; Gelso & Hayes, 2007; Hayes, 2004; Najavities, 2000; Pope Greene & Sonne, 2006), there has also been a general resistance and reluctance among therapists to talk openly about their vulnerabilities, which has also inhibited research into the construct, contributing to a lack of empirical scrutiny. According to psychoanalyst and psychologist Mills (2004), many therapist's view countertransference as detrimental to therapy, which has led to the construct being deemed, either irrelevant or something to hide, due to fears about negative judgement, criticism and professional exposure by colleagues.

This is perhaps why most of the research into the construct has taken place in a laboratory setting, using analogue studies based on hypothetical situations and scenarios (e.g. Brody & Farber, 1996; Hayes & Gelso, 1993; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Sharkin & Gelso, 1993). While it could be argued that these studies have been useful in expanding and advancing current understandings of countertransference, in that they suggest that therapist's feelings do affect the way they respond towards their clients (Hayes, 2004), it could also be argued that they say very little about countertransference in the real world or have any real 'ecological value' (Hayes, 2004, Kachele, Erhardt, Seybert & Buchholz, 2015). Furthermore, given that these studies tend to only offer participant's formed choice responses or prepared written statements, they perhaps limit what can be captured of the actual process under investigation.

More recently, however, there has been a move by some researchers out of the laboratory and into the field (e.g. Fauth & Williams, 2005; Hayes, 1995; Hayes, Riker & Ingram, 1997; Van Wagoner, Gelso, Hayes & Diemer, 1991). One common focus of interest has been exploring how countertransference management relates to therapy outcome (e.g. Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Sharkin & Gelso, 1993; Van Wagoner, Gelso, Hayes, & Diemer, 1991). This seems to mirror research into therapy more widely on the therapeutic relationship and therapy outcomes (Lurborsky, Christoph, Mintz & Auerbach, 1998; Mearns & Coopers, 2010; Wampold, 2001). While it could be argued that these studies into real therapy situations have more credibility, because they are reliant on self-report measures, they are not without limitations. While self-report instruments and measures are an efficient way of gathering data, especially when studying larger numbers of participants, they can lack 'construct validity' when different measures are used across studies, as it is difficult to know with any certainty what is being measured (Fauth, 2006, Friedman & Gelso, 2000). This is further complicated by the fact that countertransference often resides outside of awareness (Fauth, 2006). Due to the methodological limitations of these studies, as well as the disparity and variance of the findings, it is difficult to develop a clear understanding of how countertransference arises within the therapy process, which may be one of the reasons it has been difficult to develop a 'unifying and organising theory' of countertransference (Hayes & Gelso, 2001, Hayes, 2004).

Qualitative studies in the field of countertransference remain scarce, while most have focused on single cases, there have been a small number which have used qualitative method's, such as, interviewing and online survey's (e.g. Cartwright & Rhodes, King & Shires, 2015; Hayes, McCracken, McClanahan, Harp, Carozzoni, & Hill, 1998; Ladany, Constantine, Miller, Erikson & Muse-Burke, 2000). Whilst case studies are useful for putting theory into practice, they have been criticised for limited utility, largely due to their lack of transferability and research rigour, due to the influence of the researcher's own bias and subjectivity (Reis, 2009).

However according to McLeod (2010), case study research is useful for building theory and testing hypotheses. While qualitative methods of research methods have challenges and limitations (El Hussein, Hirst, Salyers & Osuji, 2014; Reis 2009), when it comes to research into countertransference, Fauth (2006) suggests they can offer the 'microanalytic' approach necessary to capture the countertransference process in a 'clinically relevant manner' (p.28). Fauth suggests that this makes qualitative research methods the most applicable research method when investigating countertransference.

Methodological debates and limitations aside, research to date into countertransference, both quantitative and qualitative, offers some support to the suggestion that the therapist needs to be aware of countertransferential material to manage it. However, what has yet to be explored is how this awareness develops in the first place. Furthermore, research has tended to focus primarily on the negative aspects and consequences; with less consideration given to the more positive elements of countertransference. Given that the theoretical literature suggests that awareness of countertransference can serve as a therapeutic tool as a source of insight into interpersonal dynamics (Beitman, 1983; Bion, 1967; Casement,1985; Coren, 2015; Gabbard, 2001; Hinshelwood, 1999; Ivey, 2008; Marroda, 2004; 1998, Oelsner, 2013; Stark, 2000; Zachrisson, 2009), this would seem to suggest it would be useful to explore both positive and negative influences of countertransference in the therapeutic relationship.

Therefore, exploring how countertransference awareness develops and whether this awareness influences the therapeutic relationship, seems like an important line of enquiry, particularly given that in-session awareness of feeling states have been shown to be both helpful and distracting (Fauth & Williams, 2005; Cartwright, Rhodes, King & Shires, 2014).Therefore, the aim of this study is to expand upon current research by exploring therapists' developing countertransference awareness and how this may or may not influence the therapeutic relationship.

Definition of Countertransference

Since its inception, the construct of countertransference has undergone several modifications within psychoanalysis (Bichi, 2012). While countertransference is broadly defined within the literature as the therapist's responses towards the client, which can include feelings, sensory, affective, cognitive and behavioural elements (Fauth, 2006), there is some debate on whether countertransference arises from the therapist's unresolved dynamics (Freud, 1910), the clients unresolved dynamics (Heimann, 1950) or within the relationship between client and therapist (Aron, 1991). This has resulted in different conceptualisations being used interchangeably despite conceptual differences (Fauth, 2006; Hayes, Nelson & Fauth, 2015; Hayes, 2004). I have adopted the relational conceptualisation that countertransference *arises from the relationship between client and therapist,* as this is closely aligned with my therapeutic approach and social constructionist epistemological position. Interestingly the terms social constructionism and constructivism also tend to be used interchangeably despite having different conceptual differences. So, while they both focus on how reality is constructed (Schwandt, 1996), McNamee (2004) argues that the constructivist approach focuses on how the individual constructs their reality, whereas social constructionism focuses on how reality is constructed through interaction, relationship and social discourse. Therefore, from a social constructionist position, I consider countertransference to be an interpersonally constructed phenomenon.

Background to the Literature review

While in most research studies reviewing the literature precedes data collection and analysis, in grounded theory research, researchers are discouraged from engaging with literature prior to data analysis and collection. This is because a grounded theory analysis should be grounded in the data and not pre-existing theories within the literature, therefore, engaging with the literature before date collection is understood to be more 'constraining' than 'guiding' (Ramalho, Adams, Huggard & Hoare, 2015).

Consequently, this can present a major challenge in the early stages of the research process for a grounded theory researcher, who needs to identify a gap in the research and fulfil the commitments of training providers and ethics committees alike (Andrews, 2006; McCallin, 2006; Ramalho et al, 2015). As McCallin (2006) suggests there is a 'fine line' between avoiding the literature entirely and ensuring the study is focused, relevant and meets any research demands. Cresswell (1994) asserts that it is 'essential' to do some reading of the literature to contextualise and frame the problem which the study is aiming to explore. Dey (1999) makes the important point that researchers often already have existing knowledge, which cannot be ignored.

Within the current study, to balance the tensions outlined above and to adhere to the guidelines of the grounded theory method, some reading of the literature was undertaken prior to data collection. This was undertaken with the aim of developing an understanding of the construct of countertransference and identifying a gap worthy of further exploration. Further reading of the literature was suspended until after data collection had begun and concepts began to develop through the grounded theory analysis. For example, the literature on containment was accessed after it had been identified as a tentative category in the analysis. Various methods were used to search the literature, these included, electronic databases: e.g. Taylor & Francis Jisc collections, Springer open, PsycArticles and the directory of open access journals; indexes to Thesis and Dissertation abstracts. The term countertransference was used to identify studies, as well as additional terms, for example, countertransference paired with awareness, containment and supervision. The bibliographies of all the articles/books were reviewed to identify relevant material/authors. Keywords within the text of the journals/books were also noted to assist with future searches of the literature.

Key terms used

Client

The language adopted to name something is more than a basic semantic exercise; words function as ‘metaphor’ and subsequently shape and influence reality and expectations (Shevell, 2009). As such, language reflects inherent values and qualities within it. Shevell (2009) suggests that the word ‘patient’ conveys illness, passivity and devalues intrinsic autonomy. In contrast, ‘client’, a more humanistic term, aims to move away from the idea of a professional ‘treating’ the ‘patient’ and instead aims to denote a more equal relationship, wherein the individual is responsible for improving their life (Rogers 1957). I will, therefore, be adopting this term.

Therapist

The term therapist has been adopted generally for this study, except for when I am referring to a specific therapeutic model, e.g. psychoanalyst, cognitive behavioural therapist.

Literature Review

The development of the construct of Countertransference

The Classical view

Before outlining the classical conceptualisation of countertransference first developed by the founding father of psychoanalysis, Sigmund Freud, (1909, 1910, 1959), it is important to consider the construct of transference. Freud understood transference as the client's feelings towards the analyst, which did not arise in the here and now, but was a displacement of feelings, which belonged to significant others from the client's early childhood. Although, initially Freud considered the transference to be a hindrance to the analytical endeavour, he later revised this view and argued that the identification and interpretation of the transference was central to the work of analysis, offering as it did a 'window' into client's formative experiences. Freud later argued that the transference stimulated the analyst's own unresolved conflicts, leading to an emotional entanglement and a distorted understanding of the client; a concept he termed countertransference and which he considered to be a hindrance and an obstacle to treatment. This negative construction of countertransference led to a prevailing view within psychoanalysis of countertransference as something that needed to be avoided and removed from treatment (Gelso & Hayes, 2007). Analysts were expected to engage in their own personal analysis as a way of scrutinising their countertransference, lest it becomes detrimental to the analysis and their understanding of the client (Burwell-Pender & Halinski, 2008; Eagle, 2000; Rosenberger & Hayes, 2002).

Freud cautioned that: *'Anyone who fails to produce results in a self-analysis of this kind may at once give up any idea of being able to treat patients with analysis' (*Freud 1910, p144).

It has been suggested that this construction of countertransference led to analysts denying their countertransferential responses as their removal through personal analysis proved to be an impossible task (Holmes & Perrin, 1997).

The Totalist view

By the 1950's an alternative understanding of countertransference was consolidating, one which suggested that while countertransference feelings in the therapist were unavoidable and could be disturbing, they also yielded valuable information about the internal world of the client (Heimann, 1950). Psychoanalyst and paediatrician Donald Winnicott's (1949) paper, '*Hate in the Countertransference'* is considered to have been pivotal in this change. Based on his clinical observations of disturbed clients, Winnicott suggested that certain clients could elicit certain reactions, including hate in the analyst. Winnicott, therefore, suggested that while countertransference could arise from the analyst's unresolved dynamics, which he called subjective countertransference, it could also arise as a reaction to the client's personality and behaviour, a response which he described as, 'objective' countertransference, i.e. a realistic reaction to the client. Consequently, countertransference was considered by some psychoanalysts to say more about the client, as psychoanalyst and psychiatrist Paula Heimann (1950) argued:

'*The analyst's emotional responses to his patient within the analytical situation represents one of the most important tools for the work; the analyst's countertransference is an instrument of research into the patient's unconscious'* (p. 1).

As a result, the Totalist perspective legitimised and normalised therapist's responses and countertransference came to be viewed as useful and worthy of further investigation (Dahl, Rossberg, Bogwald & Hoglend, 2012; Holmes & Perrin, 1997; Mills, 2004).

The Relational view

The development of a ‘two-person’ understanding of countertransference can be traced back to the work of psychoanalyst Sandor Ferenczi (1919, 1933). Unlike Freud, Ferenczi considered countertransference to be an integral part of the psychoanalytic relationship, which could never be removed entirely (Meszaros, 2004; Rachman, 2007).

Ferenczi (1919) argued instead that:

‘Even the analysed individual is not so independent of peculiarities of character and actual variations of mood to render the supervision of countertransference superfluous’ (p. 263).

Today, Ferenczi is now regarded as the ‘founder of all relationship-based psychoanalysis’, due to his understanding of the relationship as a ‘two-way process’ (Haynal, 2002 p. xi). His ideas have been influential in the shift away from a ‘monadic’ theory of mind, a ‘one-person’ psychology, towards a relational theory of mind, a two-person psychology (Aron, 1990; Mitchell, 1988; Mitchell & Aron, 1999). The one-person psychology, which permeates much of Freud’s psychoanalytical theory, privileges an intra-psychic explanation of the inner world of the individual, focusing on internal processes, such as unconscious motivations, desires and fantasies (Aron, 1990; Mitchell, 1988; Mitchell & Aron, 1999). In contrast, the relational theory of mind, privileges an interpersonal explanation, which focuses on relationships and transactions, situating the mind firmly within the social realm (Aron, 1990; Mitchell, 1988; Mitchell & Aron, 1999). Contemporary relational theorists, therefore, reject the view that countertransference can always be linked to the intra-psychic world of the client; the therapeutic focus is on an intersubjective encounter with two people contributing to the relationship (Bass, 2015), as countertransference is conceptualised as operating within a ‘bi-personal field’, and will inevitably arise in the interaction (Langs, 1978, cited in Hoffman, 1983, p.396).

While agreeing that the countertransference offers valuable information on the client, relational theorists argue that it also reveals much about the analyst (Bass, 2015). The role of the analyst is, therefore, to decipher and identify the contribution of both parties in the therapeutic dyad (Bass, 2015).

Within contemporary psychoanalytic literature and practice, there is a general agreement that working with the transference and countertransference is an important component of the clinical work. If managed, countertransference can yield important information on the client-therapist relationship; if unmanaged, it can become an impediment to the work (Casement, 1985; Gabbard, 2001; Marroda, 2004; Rowan & Jacobs, 2002; Stark, 2000). Contemporary debates are therefore no longer focused upon whether a therapist should have emotional responses and reactions to their clients, but rather on what material belongs to whom and, when countertransference is identified, what course of action should be taken (Holmes & Perrin, 1997). Before exploring managed and unmanaged countertransference, it is important to briefly consider how key therapeutic approaches conceptualise both countertransference and the therapeutic relationship, as there are some fundamental differences.

Countertransference and the therapeutic relationship

A growing body of evidence indicates that an essential element in the change process for the client, is the quality of the therapeutic relationship; this appears to be more important than therapeutic modality or the theoretical orientation of the therapist (Binder & Strupp, 1997; Charura & Nicholson, 2013; Cooper, 2004; Gelso & Carter, 1994; Greenson, 1967; Lurborsky, Christoph, Magnavita, 2000; Mearns & Coopers, 2010; Mintz & Auerbach, 1998; Wampold, 2001). However, there is a lack of consensus, within and between the different schools of therapy regarding how the therapeutic relationship is defined, the weight that should be given to its various components or indeed what these components are (Gelso & Carter, 1994). Counsellors researching the field (Cooper & McLeod, 2011) suggest that this has resulted in a lack of agreement on what therapists ‘actually do to make the relationship happen’ (p.36).

Within humanistic therapies, the relationship is viewed as the vehicle for client change; how the client experiences the therapist considered one of building blocks within the client-therapist relationship (Rogers, 1957). Within the relationship, the focus is primarily on the client, with the therapist's aims, intentions and techniques considered of less importance than meeting the client in the here and now (Mearns & Cooper, 2010). Historically the construct of countertransference has been viewed as incompatible within the humanistic framework, with some humanistic theorists suggesting that focusing on countertransference devalues 'the genuine encounter' between client and therapist in the here and now (Wilkins, 1997, p.40). However, counselling psychologists Omylinska-Thurston and James (2011) suggest that there is an accord between countertransference and the constructs of 'congruence and incongruence'. They suggest that awareness of incongruence is the same as having awareness of countertransference, as both concern the therapist's feelings and responses to the client, which can either enhance or reduce the effectiveness of therapeutic encounter (Omylinska-Thurston & James, 2011; Owen, 1999; Wilkins, 1997). Given that this focus is on what is readily accessible to the therapist's awareness (Gelso & Hayes, 2007; Omylinska-Thurston & James, 2011; Tudor & Worrall, 1994; Wilkins, 1997), would seems to suggest that they perhaps are not as synonymous as some might argue.

For cognitive behavioural therapists (CBT) the relationship, while considered important, is considered secondary to the therapeutic task; the application of techniques is the focus for client change, rather than the therapeutic relationship itself (Josefowitz & Myran, 2005; Leahy, 2008; MacLaren, 2008). In recent times a small number of CBT authors have suggested that there is a necessity to pay attention to and manage countertransference, which they suggest can on occasion arise in the work (Cartwight et al, 2014; Cartwright, 2011; Haarhoff, 2006; Leahy, 2008; Prasko, Diveky, Grambal, Kamaradova, Mozny, Sigmundova, Slepecky & Vyskocilova, 2010; Rudd & Joiner, 1997).

It has been suggested that this interest has arisen largely because CBT therapists have expanded their remit and are now working with more complex presentations, for example with clients diagnosed with personality ‘dis-orders’, where an understanding of interpersonal dynamics is required (Ivey, 2013; Haarhoff, 2006). Clinical psychologist and writer, Ivey (2013) argues that this development has led to CBT theorists constructing countertransference as an intermittent phenomenon, which only arises when resistances and alliance ruptures are apparent; it is not consistently applied to all client-therapist relationships (Ivey, 2013). Given that CBT adopts a positivist epistemology, which doesn’t acknowledge the unconscious, or gives credence to anything outside the therapist’s awareness, some have argued that the construct of countertransference is incompatible with a CBT approach (Gelso & Hayes, 2007; Haarhoff, 2006; Sussman, 2007).

Countertransference enactments

Before exploring the difference between unmanaged and managed countertransference in the therapeutic relationship, it is first important to first offer some definition of countertransference enactments. Within the psychodynamic literature countertransference arising in the client-therapist relationship is often conceptualised as a countertransference enactment (Hansen, 1997). Enactments are understood to encompass both verbal and non-verbal elements (Gabbard, 2001) and to contain two essential elements, the stimulation of strong, unconscious affect and some resulting behaviour from both parties (Maroda, 1998). According to psychoanalyst Hinshelwood (1999), the intention of the enactment is to change the relationship rather than articulate the ‘pain’ of it.

While there is a consensus amongst classical and relational practitioners and theorists on the importance of the enactment in therapy (Cramer, Osherson & Hatcher, 2016; Gerrard, 2007), there is disagreement on the origin of the enactment. The classical understanding views the enactment as driven by the client’s transference towards the analyst, which the analyst is pulled into responding (Ivey, 2008).

In contrast, the relational understanding considers the enactment as relating to both members of the analytic dyad, with each unwittingly 'acting' out past events and/ or emotional experiences, roles and memories (Cramer, Osherson & Hatcher, 2016; Devereux, 2006; Maroda, 1998; McLaughlin, 1991).

As relational psychoanalyst Owen Renik puts it:

'There aren't enactments (plural); there is only enactment (singular), a constant, unavoidable aspect of everything patient and analyst do in analysis' (1997, p. 281).

It is suggested that clients often will enact their interpersonal patterns of relating within the therapeutic relationship and will assign or project a role onto, or into, the therapist. Role responsiveness was put forward by psychoanalyst Joseph Sandler (1976) to explain how clients pull analysts into behaving in ways, which conform to the client's internal role relationships. Sandler asserts that when the client casts the analyst into the role, it might need to be acted out before the analyst can be aware of the role in which he has been cast. Stark (2000) suggests that if the therapist can remain open to playing the role assigned by the client, this can offer valuable insights into the client's world by enabling the therapist to experience the client's interpersonal dynamics. This suggests how countertransference awareness can be used in the service of the client.

However, Sandler cautions against attributing all the feelings arising in the analysis to the client.

'*Let me say emphatically that I am absolutely opposed to the idea that all countertransference responses of the analyst are due to what the patient has imposed on him' (*Sandler, 1976, p. 46).

While managed countertransference has the potential to yield important data on both the client and the therapist dynamics, when these powerful dynamics remain unattended to, they can be detrimental to the therapeutic relationship. The dangers and benefits of unmanaged and managed countertransference will now be explored.

Unmanaged countertransference

This ability to contain the client's projections can be an extremely difficult task and at times the therapist can become overwhelmed and defensive, resulting in a failure of containment (Hansen, 1997). These difficulties in managing countertransference can result in a breakdown in the therapeutic relationship (Casement, 1985; Coren, 2015; Gabbard, 2001; Hinshelwood, 1999; Ivey, 2008; Maroda 2004,1998; Rowan & Jacobs, 2002; Stark, 2000; Zachrisson, 2009). According to psychologists Safran and Kraus (2014), unexamined countertransference enactments lead to empathic failures, therapeutic impasses and/or a complete breakdown in the therapeutic alliance between client-therapist in the relationship. Parallels have been drawn between these and misattunements in the mother-infant dyad (Safran & Kraus, 2014).

According to Waska (2010), therapists can be pulled, albeit unconsciously, into acting out their countertransference in various ways, such as punishing the client, becoming seductive towards them or withdrawing. Waska suggests that this can then potentially validate or intensify the client's existing beliefs regarding relationships. Schaeffer (2007) suggests that this repeating of old patterns enables some clients to feel safe as it creates a familiar relationship pattern, even though this may be harmful to the client. Additionally, Najavitis (2000), has suggested that when clients are discussing material which relates to the therapist's unresolved issues, the therapist may respond in either a defensive manner or avoid client material altogether. Najavitis (2000) suggested that this then has the potential to rupture the working alliance, as the response meets the therapist's needs rather than the client's, who is then likely to feel undermined by the therapist's defensive or avoidant behaviour. According to McClure and Hodge (1987), some therapists appear to view positive feelings towards clients as synonymous with a positive outcome and negative feelings with a negative outcome.

However, they suggest, either response has the potential to be facilitative or destructive. For example, when a therapist experiences an over-identification, with a client, this could result in the therapist being unable to separate from the client's material, whereas, when a therapist isn't able to identify with the client's material, this could lead to distancing behaviours on the part of the therapist. Both responses are likely to be non-facilitative for the client and the therapeutic process. Similarly, Watkins (1985) notes several ways in which the countertransference enactment could be non-facilitative, such as, when a therapist becomes over-protective towards the client or prevents a client from experiencing certain feelings, such as anxiety, guilt or anger. According to Watkins, these responses do not facilitate the resolution of the client's difficulties. Friedman and Gelso (2000) have also cautioned that when therapists engage in countertransferential behaviours, such as, agreeing too much, engaging in too much self-disclosure and being over-supportive, these can become detrimental to the relationship preventing clients from exploring conflictual issues (Friedman & Gelso 2000).

Managing countertransference

The literature suggests being able to manage countertransference so it can be utilised to the benefit of the therapeutic relationship, requires the therapist to be impacted by the client, while remaining grounded within his or her own self (Geller, 2013). This dual awareness enables a therapist to monitor their own experience in the therapeutic relationship to better understand both the clients and their own dynamics (Leitner, 1995). Clinical psychologist Leitner (1995) has described this relational connection as the provision of an optimal therapeutic distance, which enables the therapist to be close enough to experience the other's feelings, while being distant enough to recognise the source of those feelings. According to Leitner (1995), achieving this optimal therapeutic distance is demanding, as it requires entering an intimate relationship with the client, while retaining a degree of separateness within one's self.

If the therapist can achieve an optimal therapeutic distance, it is suggested this will enable the therapist to stay emotionally present, without being overwhelmed by the experience (Moltu, Binder & Nielsen, 2010). It has been suggested that if a therapist can offer a holding and containing environment, where the enactment can be experienced and reflected on, the therapist is then able to find a new way of being with the client, which is sufficiently different from the repetitive experiences that the client consistently enacts in their relationships with others (Christian, Safran & Muran, 2012). This it is suggested, then has the potential to offer the client a reparative or corrective experience, resulting in growth and interpersonal change (Christian, Safran & Muran, 2012; Goldfried, 2012; Sharpless & Barber, 2012).

Bion (1961) argued that the therapist's containing role was much like the mothers; taking in hostile projections, and through a sifting of the feelings and thoughts, giving shape and meaning to the experience, a process Bion described as 'reverie'. Through reverie, Bion suggests, the therapist holds and contains the client's emergent emotion and dynamics, which allows the client to share feelings, which previously were too painful or shameful to share. The relationship with the therapist, therefore, offers the chance to disconfirm fears regarding the consequences of expressing otherwise repressed and defended against material (Christian, Safran & Muran, 2012). Through the experience of containment, Bion suggested the client would introject the experience, facilitating growth and development. Psychoanalyst Patrick Casement (1985) outlined a similar concept, '*analytic holding* ', which he linked with empathy: This is the capacity to tolerate and attune with the client's feelings while remaining a grounded and a functioning therapist:

'Patients have taught me that when I allow myself to feel (even be invaded by) the patient's own unbearable feelings, and I can experience this (paradoxically) as both unbearable and yet bearable, so that I am still able to find some way of going on, I can begin to 'defuse' the dread in a patient's most difficult feelings' (p154).

The holding environment, according to Winnicott (1956, 1957, 1960) was the optimal environment where 'good enough parenting' took place, which enabled the infant to develop and grow towards an independent existence. According to Winnicott the therapist, much like the mother, if able to offer a holding environment, could offer the client a reparative experience. However, being able to tolerate and manage difficult clinical material, first required the therapist to have an integrated self and cohesive identity (Mahapatra, Sahoo, Mishra & Kumar, 2010).

Self-integration refers to the presence of an intact and stable character structure, where the self is more unified than disorganised (Hayes, Gelso, Wagoner & Diemer, 1991). An inherent aspect of an integrated self is strong ego strength, a psychodynamic construct, which refers to an individual's capacity to tolerate and deal with internal affect, such as, anxiety, and external stressors, enabling affective coping and personal and interpersonal functioning (Bjorklund 2000; Mahapatra et al, 2010; Qarachanaq, Pormouzeh & Loo, 2015; Shepherd & Edelman, 2009). Possessing ego strength arising from a cohesive self-structure increases the therapist's capacity to manage anxiety adaptively in the presence of the client's often overwhelming affect (Van Wagoner et al, 1991). It has also been suggested that to develop an integrated self requires a level of awareness to have developed, whereby therapists are more able to identify and recognise their own thoughts, feelings and behaviours and less inclined to misattribute these to their clients (Hayes et al, 1991).

The development of countertransference awareness

Pope, Greene & Sonne (2006) suggest that training programmes, which provide both opportunities for reflection, and a framework, which attends to interpersonal dynamics, are more likely to support the development of countertransference awareness.

Research findings also indicate that the development of countertransference awareness also requires a theoretical framework. In their analogue study, Robbins and Jolkovski (1987) explored how trainees managed their countertransference feelings. 58 doctoral counselling and clinical psychology trainees, watched three videotapes of client sessions, and at 10 points in the video were asked to select an intervention from a written protocol. The study found that when higher levels of awareness of countertransference were accompanied by the ability to conceptualise countertransference reactions, participants were more likely to maintain involvement with the clients. In contrast, lower levels of awareness were associated with withdrawal responses. This study found that managing countertransference responses not only required therapists to be alert to their feelings but that they also needed a theoretical framework to make sense of any feelings and responses once they had been identified. The study concluded that theoretical framework without self-awareness, however, did not reduce withdrawal behaviours, suggesting that intellectual processes alone were not sufficient to remain engaged in the therapeutic relationship.

This suggests managing countertransference requires more than an intellectual understanding, a finding supported by a recent pilot study conducted by Cartwright & Rhodes, King and Shires (2015), which explored whether training in identifying countertransference awareness aided its development and management. 55 clinical psychology trainees' responses to a teaching and learning method for conceptualising and managing countertransference were explored using an online questionnaire. Most participants reported that having a framework to conceptualise their responses had increased their awareness of their countertransference. However, while participants reported that training had helped them to value and pay attention to their countertransference responses, they still struggled to apply their learning to practice. While the findings outlined above are helpful in identifying factors which might support countertransference awareness, how this develops remained unexplored.

In supervision

It has been suggested that clinical supervision which offers the opportunity to reflect on the relationship between therapist and client, supports the development of countertransference awareness (Burwell-Pender & Halinski, 2008; Kumari, 2011; Pakdaman, Shafranske & Falender, 2015; Watkins 1985). Clinical psychologists, Pakdaman, Shafranske and Falender (2015) suggest that supervision may be the only place where difficult and challenging feelings and responses can be discussed. According to clinical psychologist and psychoanalyst Mollon (1989), the role of the supervisor is to facilitate the trainee's capacity to think about the process of therapy, a process that he likens to Bion's (1962) concept of 'reverie'. Mollon suggests that countertransference awareness requires a certain degree of reverie in the supervision space, which ultimately will be internalised by the trainee.

This suggestion is supported by a qualitative study by Schwing, LaFollette, Steinfeldt and Wong (2011), who interviewed and analysed the diaries of three trained therapists; supervision was identified as helpful in developing therapists' confidence in managing countertransference responses. The findings from this study suggest that learning how to manage countertransference required openness to sharing countertransference responses in supervision. While this was a very small sample, these findings indicate that sharing challenging aspects of the work is dependent on the supervisee's willingness to disclose, as well as the supervisor encouraging such disclosures (Pakdaman, Shafranske & Falender, 2015; Ponton & Sauerheber, 2014).

In personal therapy

The relevance of personal therapy during therapist training has been widely debated in both the theoretical and research literature, resulting in two camps: those who have argue that it is essential for the development of self-awareness, insight, understanding and personal development in trainees (Barnett, 2007; Bike, Norcross & Schatz, 2009; Gil & Rubin, 2005; Grimer & Tribe, 2001; Kumari, 2011; Macdevitt, 1987; Mander, 2004; Myers, 2010; Orlinsky, Norcross, Rønnestad, & Wiseman, 2005; Tobin, 2003; Watkins, 1985; Wiseman & Shefler, 2001) and those who argue that there is no empirical evidence that personal therapy is linked to improved client outcomes (Atkinson, 2006; Clarke, 1986; Dryden & Thorne, 1991). Malikiosi-Loizos (2013) suggests that therapeutic approaches which focus less on the person of the therapist, for example, CBT, tend to view personal therapy as having less importance, compared to insight orientated therapies, such as psychodynamic therapy, which sees the therapist as highly important in the therapeutic encounter. Within the psychodynamic literature personal therapy has been viewed not just as desirable but as a pre-requisite to clinical training (Norcros, 2005) as it is widely agreed that all therapists have vulnerabilities, desires, needs and 'wounds' and therefore have a responsibility to develop their awareness of these to ensure that they are not detrimental to the work (Higdon, 2012, Wheeler, 2002). Psychotherapist Barnett (2007) cautions against the therapist who avoids exploring their vulnerabilities and motivations for the work, as Barnett suggests this may lead to the therapist unconsciously using the client in some way.

There is some empirical support for the role personal therapy can play in developing countertransference awareness. Bike, Norcross and Schatz (2009) conducted an extensive survey of 600 psychologists, counsellors and social workers and personal therapy was described as increasing awareness of personal dynamics, client-therapist interpersonal dynamics and countertransference awareness.

Furthermore, participants said it also enhanced their presence, tolerance and empathy within the therapeutic relationship. Wiseman and Shefler (2001) interviewed five experienced psychoanalytically orientated psychotherapists about their experience of personal therapy and its subsequent impact on their personal and professional development. Findings from this study indicate that personal therapy played an important part in participant's process of individuation and in the development of their ability to use their self and to achieve authentic relatedness with clients. Participants in this study stressed the fundamental need for the therapist to work in personal therapy on improving his or her self-knowledge by getting to know all aspects of the self.

Self-awareness has been shown to play an important part in managing countertransference. A study by Van Wagoner et al, (1991) explored 129 'excellent' and' general' therapists' management of countertransference using a questionnaire to explore therapist self-insight, self-integration, conceptualisation, empathic ability and anxiety management. 'Excellence' was determined based on extensive knowledge, scholarly writing, and/or empirical investigation in the areas of transference and countertransference. These researchers concluded that 'excellent' therapists had more insight into their feelings, which enabled them to have a greater capacity to empathise. These therapists were viewed as more integrated as well as possessing an intellectual understanding of client emotions; and more able to differentiate the client's needs from their own. While this study makes an important contribution to the field, in that it offers a useful theory on how to manage countertransference, what remains to be explored is how these abilities developed in the first place.

Barriers to the development of countertransference awareness

According to several authors (Hill, Sullivan Knox & Schlosser, 2007; Marroda, 2012; Skolholt & Ronnestad, 2003; Theriault, Gazzola & Richardson, 2009; Stefano, D'luso, Blake, Fitzpatrick, Drapeau & Chamodraka 2007; Truell, 2001), the developmental journey of therapists in training can be particularly difficult as trainees struggle to develop the necessary experience, self-awareness and reflective skills, which would enable them to manage the anxiety generated by the work. These theorists suggest that the overwhelm generated by the training acts as an impediment to the work, as many trainees struggle to retain their focus on the client, as they become caught up in the need to manage their countertransferential responses.

Internal Barriers

It has been suggested that trainee therapists are often prone to the experience of shame arising from their own limitations and vulnerabilities (Barnett, 2007; Hahn, 2001; Molad, 2011; Mollon, 1986). According to Barnett (2007), trainees often strive for perfection, a desired idealised image of themselves, as a way of defending against feelings of not being good enough (Barnett, 2007). Narcissistic vulnerability is a concept originating with psychoanalyst Kohut (1971, 1977), which was further elaborated by psychologist and psychoanalyst, Miller (1981). According to Kohut & Miller, Narcissistic vulnerability develops when the caregiver fails to mirror the 'normal' narcissistic needs of the infant; the infant's specialness, which impacts on the infant developing a cohesive self. This leads to a fragile and fragmented self and gives rise to feelings of shame, inadequacy, and a feeling of not being good enough. Therapists who have unresolved narcissistic issues, such as, feeling not good enough, according to Mollon (1986) may struggle with the ambiguous nature of therapy, or the nature of countertransference enactments, which may leave them feeling ineffectual.

Counselling psychologists Skovholt and Ronnestad (2003) suggest that some therapists in training have ‘glamourised expectations’ arising from the need to ‘heal’ their clients. As a result, these trainees develop high expectations of the impact their efforts can have:

‘If I am able enough, skilled enough, warm enough, intelligent enough, powerful enough, knowledgeable enough, caring enough, present enough, then the other will improve’ (p9.).

These researchers have suggested that trainee’s evaluation of their competence becomes intrinsically entwined with therapeutic outcomes, creating anxiety and pressure, when they perceive they have failed to meet expectations. According to Casement (1985) trainees have an ‘omniscient’ need to know what to do, a need Casement suggests, is naturally frustrated during training, as trainees have yet to develop their clinical and technical knowledge. Casement suggests that because trainees expect that they should know and consider this expected of them by the client and the supervisor, their lack of knowledge can result in a feeling of not being good enough.

These findings are supported by a qualitative study carried out by Stefano, D’Iuso, Blake, Fitzpatrick, Drapeau and Chamodraka (2007) into trainee’s experiences of impasses in counselling. Findings from this qualitative study indicate that trainees reacted negatively to therapeutic impasse, which was constructed as a failure, as trainees felt that there was a ‘right’ way to intervene, which they had failed to grasp. Many of these participants reported reverting to basic listening skills in these cases; a method of coping, which was found to be ineffective in addressing the tension and conflict that they felt in the room. Truell (2001) in a qualitative study into the stressors inherent in counselling training interviewed six recently graduated therapists. Participants reported having expectations early on that they should be able to solve all their client’s problems and that they should be able to acquire counselling skills with ease and perform them perfectly.

Participants also described struggling with acting out the skills of a therapist, such as empathy, when this was not how they really felt. Truell (2001) concluded that many trainees believed they needed to have resolved their own personal conflicts, as difficult feelings experienced in the work were constructed as a sign of failure.

External Barriers

For some therapists-in-training, disclosing countertransference feelings and responses in supervision can be difficult for the reasons outlined above. This can then lead to fears of being judged and criticised in supervision (Skovholt & Ronnestad, 2003; Yourman & Farber, 1996; Yourman, 2003). According to Skovholt and Ronnestad (2003), supervision can increase rather than decrease trainees level of anxieties, as they can be highly receptive to negative feedback. Willingness to disclose countertransferential responses is also highly dependent on the supervisor's invitation to disclose, as well as their ability to normalise the trainee's experience (Ladany, Constantine, Miller, Erickson, & Muse-Burke, 2000; Southern, 2007). However, as Bridges (1998) notes, many supervisors don't have the skills or confidence necessary to help supervisees examine their own material, which can restrict supervisory discussions to an exploration of client data. In addition, some supervisors and trainees may focus solely on the client as a way of ensuring a boundary between supervision and therapy, but in doing so, neglect crucial areas of psychotherapy process, such as, mutual enactments. Mollon (1986) is critical of this type of supervisory approach and suggests that it fails to facilitate the trainee's capacity to think and feel freely about therapy and their own narcissistic vulnerability, resulting in trainees feeling shamed by their perceptions of their own incompetence. Mollon suggests it is by attending to trainees feeling of incompetence and uncertainty that these feelings become tolerated and the trainee learns a great deal more about their interactions with their clients.

To practice effective psychotherapy, according to Mollon (1986), relies on the trainee's capacity to withstand these 'narcissist blows', with the support of the supervisor essential to facilitate a thinking space to contain the narcissistic injuries inherent in learning. This containment can also be provided by the training culture of the organisation. Mollon suggests many problems arise for trainees when transference and countertransference are not covered in the training curriculum, particularly in trainings where there is a focus on the client and not on the responses of the therapist. Mollon suggests that trainees are likely to struggle when these issues are not covered, which will inevitably cause narcissistic injuries, particularly when trainees are working with disturbed clients. According to psychoanalysts Glickauf-Hughes and Mehlman (1995), because trainees are exposed to constant evaluation while training, the training experience itself creates a great deal of anxiety and narcissistic vulnerability. According to psychoanalyst Eckler-Hart (1987), the training experience may also contribute to trainees developing a false professional self, as they may feel they need to conduct themselves in an overly competent manner to meet the expectations of the profession and avoid negative evaluation and criticism.

There has also been some suggestion that the therapeutic approach can be a barrier to developing countertransference awareness. CBT, for example, is viewed as a standardised treatment model, and therefore the vulnerabilities, issues and conflicts of the therapist, are considered less of an issue in this type of therapy (Gelso & Hayes, 2007; Milton, 2001). According to Ivey (2013), this suggests that CBT therapists construct themselves as, more or less, transparent to themselves, as well as being saner and less conflicted than their clients, an assertion, Ivey strongly disputes. Likewise, Gelso and Hayes (2007) are critical of this position, as they suggest that it is extremely doubtful that therapy really can be offered in such a formulaic way or indeed if the person of the therapists can be removed from the equation completely. They suggest this creates a culture where the therapist can avoid investigating their own vulnerabilities.

Milton (2001) suggests this has resulted in CBT therapists being less equipped to understand and make use of their countertransference, which they are more likely to enact in the therapeutic relationship. According to Mollon (1986) training, which does not attend to these issues, will not prepare trainees for the emotional realities of the work and this inadvertently will leave trainees/therapists 'handicapped' by their training culture. Psychodynamic practitioners Price and Paley (2008) argue that therapists working within the NHS face many internal and external stressors, which can leave them feeling uncontained, which then impacts on the therapist's ability to contain their clients. This seems to be supported by a study carried out by Rizq, Hewy, Salvo, Spencer, Varnaseri and Whitfield (2010), which explored the experiences of training and practice, for five primary mental health care workers (PCMHWs). The study set up a reflective practice group, where many of the participants described ways in which they struggled to deal with a range of emotions in themselves and in their clients during clinical work, which left them feeling, both anxious and frustrated, with their clients. Participants felt that their CBT training had not equipped them to make sense of and manage some of their difficult emotions. Furthermore, they felt an understanding of countertransference would have been highly beneficial.

Summary

In summary, there are differing views on whether countertransference is a significant feature of the client-therapist relationship, with the psychodynamic literature giving the construct the most credence. While the benefits of countertransference awareness are widely agreed within the relational psychodynamic literature, what has yet to be explored is how countertransference awareness develops, what facilitates or hinders this development, and how this awareness may or may not impact the therapeutic relationship.

Relevance to Counselling Psychology

Underpinned by a humanistic ethos, the relational interchange between client and therapist is constructed as the cornerstone of the therapeutic relationship within counselling psychology (Williamson, 2013). So, while counselling psychology does not privilege one theory over another, but attempts to synthesise and integrate different models and approaches (Woolfe, Strawbridge, Douglas & Dryden, 2010), it does privilege an understanding of therapy as an intersubjective encounter between 'relational beings' (Milton, 2011). This is reflected in the divisional practice guidelines (2005), which stipulate that counselling psychologists need to reflect on their practice, with counselling psychology training supporting counselling psychologists to identify, understand and manage their own responses. It is hoped that the findings of the current study will contribute to an improved understanding of these processes.

The rationale for the study

How countertransference awareness develops and what influence this may or may not have on the therapeutic relationship has yet to be explored. It is hoped that this study will make a useful contribution to current research into countertransference and therapeutic practice, as it aims to offer a theory of the processes involved in developing countertransference awareness and its relationship to the therapeutic encounter.

Research aims and objectives

The aim of this research is twofold: to explore therapist's developing countertransference awareness and how this may or may not influence the therapeutic relationship and secondly, to develop a grounded theory of this process.

Methodology

Introduction

Any research design involves the intersection of the underpinning philosophy of the researcher with the specific method and procedure of the enquiry (Cresswell, 2014). According to research authors Guba and Lincoln (1994) the basis of any underpinning philosophy can be separated into three fundamental questions; the ontological, the nature of reality; the epistemological, what is known about reality and the methodological, how the enquirer finds out what they believe to be known about reality (p. 108).

Positioning of the researcher

In qualitative research, it is common for the researcher to make their stance or worldview explicit for the reader, as this framework both guides the researcher and the research process and design (Denzin & Lincoln, 2000; Morrow, 2005; Ponterotto, 2005). Making the position of the researcher explicit at the outset, therefore, should indicate whether there is a clear *fit* between the researcher's stance, the research question, the methodology and the methods they have adopted (Morrow, 2005). It is important to acknowledge with any set of beliefs, no matter how well argued, that they do not represent the truth; there is no way of elevating one belief or worldview over another (Guba & Lincoln, 1994). Therefore, I do not claim in any way that my position is more valid than another's, but merely is the position that I hold. As a *relational* trainee-counselling psychologist, I consider the therapeutic endeavour as a two-way, intersubjective process, one that is co-constructed between myself and the client, through a therapeutic dialogue (Buirski & Haglund, 2010; O'Brien, 2010). In both life and in practice, I believe that we can never fully see the world through the eyes of another, but only through interpretation, construction and through relationship (Charmaz, 2008; Mahoney & Neimeyer, 1995; Ponterotto, 2005).

As such I believe that meaning is always co-constructed through the process of joint enquiry, and through the interaction between therapist and client (Tarragona, 2008). I subscribe to the view that therapy is a place where client's stories and histories are constructed and re-constructed within a particular context and time, giving birth to new meanings and new ways of relating (Andrews, 2012; Buirski & Haglund, 2010). I do not believe in the existence of a single story and I'm mindful of the inherent power and oppression that can reside in the idea of a single narrative.

My understanding of research has been guided by what I hold as relevant and conducive to the real work of therapy, as described above; I do not claim to hold an objective view of my participant's experiences but, as with the process of therapy itself, I acknowledge that any meanings and experiences, while initially interpreted and constructed by the participants, have been further interpreted and constructed again through my interaction with the research process (Charmaz, 2006, 2008). I position myself as critical realist, as while I consider there to be a reality independent of my thinking, I do not believe I can objectively apprehend that reality (Trochim, 2006), but instead, consider reality to be socially constructed, through relationship and dialogue (McNamee, 2004).

Ontology – Critical Realist

A critical realist ontology considers there to be a reality which exists independent of an individual, but that this reality can only be known imperfectly and never fully known with any certainty (Guba & Lincoln, 1994; Kempster & Parry, 2011; Trochim, 2006). This contrasts with a positivist ontology, which believes in a single observable reality, which can be known through scientific enquiry (Guba & Lincoln, 1994; Trochim, 2006). Critical realism challenges this view of objective truth arguing instead that observations are theory-laden and inherently biased by experience, social, cultural influences and reality can only be a construction based on these beliefs and perceptions (Trochim, 2006).

Epistemology - social constructivism and social constructionism

Social constructionism has its origins in sociology and has been associated with the post-modern era in qualitative research (Andrews, 2012). Postmodernism rejects the positivist belief of an absolute truth and notion of a single objective external reality (Schwandt, 1994). It asserts that people construct different 'realities' that are socially constituted and therefore may vary quite dramatically across culture, time and context (Guba & Lincoln, 1994; Ponterotto, 2005). Within the literature, the terms social constructivism and social constructionism tend to be used interchangeably and subsumed under the generic term 'constructivism' because they both reflect a postmodern epistemology (Andrews, 2012). For example, Charmaz (2006) claims the terms social constructionism and social constructivism have become interchangeable in contemporary literature, in relation to grounded theory. However, while these two theoretical stances converge in both psychotherapy and academic dialogue in their focus on meaning making processes and how the social and personal emerge (McNamee, 2004), they also differ significantly in how they understand reality to be constructed (Andrews, 2012; Van-Niekerk, 2005). It is important therefore to highlight this difference; according to McNamee (2004), constructivism, privileges the individual and asserts that reality is constructed from the intra-psychic realm, whereas, social constructionism, privileges discourse and social activities and interactions that transpire between people, where knowledge and truth are created, not discovered by the mind (Van-Niekerk, 2005). As McNamee asserts the starting point is the relational as opposed to the individual:

'It's not what is in the head but what people are doing together that is of concern' (p.3).

Therefore, social constructionism moves away from individual internal processes towards a focus on the ways in which people engage and interact together.

The psychodynamic perspective and a qualitative approach

According to Hinshelwood (2013), psychodynamic research has been criticised as lacking any real scientific evidence base, as its theories and knowledge have not been rigorously tested with scientific methods, to the same standard of medical and other scientific disciplines. Hoffman (2007) writing about the relevance of the single case study in psychoanalysis, argues part of the problem is that currently systematic research and neuroscience, while valuable, has been granted a 'superordinate status, relative to other sources of knowledge', which he suggests is both 'unjustified and potentially destructive', when human experience and therapeutic process cannot be objectively measured (p. 1044). Furthermore, because the researcher's subjectivity cannot be separated from the research process, methods of enquiry are needed which acknowledge that meanings and understandings are not objectively discovered but constructed through the research process (Luca, 2016). Anthropologist and psychoanalyst Devereux (1967) was the first to suggest that countertransference was as much part of the research process as the therapeutic process, with the researcher observed by the participant and vice versa. As Holmes (2014) highlights, research is much like therapy, it involves 'two people coming together, therefore the behaviours, words and actions of one, is likely to influence the other' (p.177). My countertransference responses arising through the research process will be discussed further in the reflexivity section below.

Rationale for a qualitative methodology

It has been suggested that positivist quantitative methods are not suitable for the study of some aspects of human experiences (Hoyt & Bhati, 2007; Polkinhorne, 2005) and that qualitative methodologies are more suited to clinical practice, as they take account of and capture, human experience (Cresswell, 1998).

Adopting a qualitative methodology is particularly suited to the study of psychotherapy processes; this method of enquiry acknowledges the subjective and interpretative nature of meaning, which is a significant element in the practice of psychotherapy (Hansen, 2004; Rennie, 1994). The term qualitative research refers both to the 'techniques' adopted for the collection and analysis of data, as well as the paradigm in which the methodology is situated (Clarke & Braun, 2013). It is an empirical method, which, like quantitative research, involves the collection, analysis and interpretation of observation or data (Ponterotto, 2005). In addition, a qualitative method of enquiry offers a flexible set of methods (McLeod, 2011), which enables the gathering of data that is rich and illustrates the phenomenon of interest intensely (Polkinghorne, 2005). Furthermore, qualitative research acknowledges that true objectivity is not possible (Morrow, 2007). Whereas quantitative researchers implement strategies to control for subjectivity, qualitative researchers recognise and understand that subjectivity, has both, potential and limitations (Morrow, 2007).

Clarke & Braun (2013, p.6) suggest that qualitative research requires a 'qualitative sensibility'; this stance mirrors the therapeutic stance of counselling psychology and the therapeutic relationship as both have:

- A focus upon processes and meanings.
- A curiosity about *why* things might be or *how* they could be different
- An awareness of how the researcher or therapist brings his or her own values and assumptions to the research process.
- A *reflexive attitude* to the multiple ways one's own position can influence the process
- The ability to develop an *analytical 'eye' or 'ear'*, to focus both on content and the possible underlying meanings and processes.
- The possessing of good interactional skills to develop rapport and trust.

Rationale for social constructionist/ constructivist methodology

According to research authors Mills, Bonner & Francis (2006) when choosing a research paradigm, it is important to remain 'congruent' with one's own beliefs about the nature of reality, as this will ensure a coherent research design. I felt that a social constructionist methodology seemed particularly appropriate for counselling psychology research generally, as both are concerned with intersubjective process, and the ways in which people engage and interact together (Mahoney & Neimeyer, 1995; McNamee, 2004). Furthermore, they also both mirror a two-person psychology as they acknowledge research is a two-person process, which recognises that meaning is constructed and understood through the interaction of the researcher and the participant (Charmaz, 2006; Ponterotto, 2005). While it could be argued that the analysis is rooted in individualism, as it focuses on what each individual participant is constructing, it is important to emphasise these meanings have been constructed with reference to others, both external and internalised, which is in keeping with a relational understanding of the 'individual'. The relational view suggests all human beings are formed by and embedded with relational interactions throughout life (Mitchell, 1988). As relational psychoanalyst Mitchell asserts:

'The individual discovers himself within an interpersonal field of interactions in which he has participated long before the dawn of his own self-reflective consciousness' (1993 p.132).

The relational view suggests that stories are not created in a vacuum, and as such, meaning making is a relational process, as internal voices are always populated with others, whether actual or imagined (McNamee, 2004). So, while the analysis adopts Charmaz's constructivist grounded theory, the understanding of individual constructions draws upon both relational and social constructionist ideas.

Classical 'objectivist' Grounded Theory

Grounded theory, one of the most established and respected qualitative methodologies, has been described as a 'market leader' in qualitative research (McLeod, 2011). The Grounded Theory Method consists of a set of systematic yet flexible guidelines for collecting and analysing data; the aim is to generate a broad, explanatory theory about the phenomenon under study, which is grounded in the data (Charmaz, 2006; Glaser & Straus, 1967).
Grounded Theory was developed by sociologists, Glaser and Strauss, from their studies of terminally ill patients in hospital (see Glaser and Strauss, 1965). In their seminal text, *The Discovery of Grounded Theory* (1967), they argued that researchers needed an alternative to research methods which focused on testing and verifying pre-existing theories. They argued that grounded theory would produce theory grounded in the data, opening a space for the development of new, contextualised theories. Grounded theory developed at a time when qualitative methods were only seen as a preliminary to the 'real' methodology of quantitative research *(*Charmaz, 1983, 2003, 2006). Glaser and Strauss (1967) challenged the idea that qualitative methods were unsystematic and could not generate theory. In this way, they strove to move qualitative research beyond the descriptive, by developing conceptual and explanatory theoretical frameworks of the phenomena under investigation, while capturing the complexities of the individual's experiences in a naturalist setting (Charmaz, 2006).

Grounded theory, therefore, has three main guiding principles: to find new ways of making sense of the social world; to generate theories in which the phenomenon being investigated can be understood and to develop a theory which is 'grounded' in the data (McLeod, 2011). However, classical grounded theory is rooted in a positivist ontology, which considers there to be one objective theory existing within the data, which will emerge through the abstraction process. Classical grounded theorists argue that if the grounded theory method is adhered to, the researchers own subjectivity will not contaminate the research process (Ramalho, Adams, Huggard & Hoare, 2015).

Social Constructivist Grounded Theory

Charmaz (2003, 2006) departed from the idea that theory was 'discovered' in the data and instead argued that it was constructed through the involvement and interactions of the researcher and the researched. The aim of a constructivist inquiry is to explore participant's constructions of their experiences and produce a 'substantive theory' (Charmaz, 2006). This approach acknowledges that the researcher cannot stand outside of the research process and therefore any theorising done is also a construction (Charmaz, 2006). Social constructivism also adheres to a socially constructed reality, which aims to capture the individual actions, interactions and social processes of the participants (Willig 2001). Taking this perspective on the nature of reality, Charmaz (2006) is naturally critical of the way in which classical grounded theorists purport to 'discover' latent patterns of behaviour within the data. Furthermore, she suggests that, rather than look for one main concern, grounded theorists should seek to construct a "picture that draws from, reassembles, and renders subjects' lives" (Charmaz, 2003, p. 270). Social constructivist grounded theory it is argued presents a more 'diffuse' theoretical product, which does not centre upon a core category (Martin, 2006, p.8). This is intended to allow for the multiple truths, with the emphasis on capturing multiple participant perspectives, rather than looking for one main concern (Martin, 2006).

Rationale for grounded theory methodology

Qualitative methodologies all seek to develop and contribute to an understanding of how the world is experienced or how it is constructed (McLeod, 2009). Braun and Clarke (2006) separate qualitative methods into two camps, those that are wedded to or stem from an epistemological position, e.g. Grounded Theory and Interpretative Phenomenological Analysis [IPA], and those which are not, e.g. Thematic Analysis [TA]. In keeping with the researcher's epistemological position, constructivist grounded theory was the most obvious choice, but consideration was given to both IPA and TA as possible approaches.

IPA is underpinned by a phenomenological epistemology, which suggests that the meanings that participants ascribe to their experiences are only accessible through an interpretative process (Biggerstaff & Thompson, 2008). In this way, IPA acknowledges the engagement of the researcher in the activity of interpretation (Biggerstaff & Thomson, 2008, Smith & Osborn, 2008). IPA differs in its interest in the common experience of a phenomenon (Cresswell, 2007), as it attempts to capture and distil a phenomenon down to a description of its universal essence (Cresswell, 2007). Participants are selected because they have all experienced the phenomenon in question so that a common understanding can be produced (Cresswell, 2007). Because the aims of the study were to explore processes rather than common experiences, IPA was ruled out as an appropriate methodology. Unlike IPA, TA is not wedded to any epistemological approach, which enables it to be used within different theoretical and epistemological positions (Braun & Clarke, 2006). TA has many similarities with grounded theory and involves both coding and the interpretation of the data (Braun & Clarke, 2006). However, while TA aims to produce conceptually informed interpretations of the data, it does not aim to produce a theory (Braun & Clarke, 2006), which was one of the aims of the current study.

Grounded theory has three main aims; it aims to make sense of the social world; to generate a theory which offers an understanding of the phenomenon under investigation, and one which is firmly grounded in the data (McLeod, 2009). Therefore, Grounded theory is considered most suited to investigating processes and areas which are under researched (Cresswell, 2007). According to Tweed & Charmaz (2012):

'Grounded theory's theoretical, epistemological and technical foundations position it well to investigate a broad range of open-ended research questions that focus on processes, patterns and meanings within contexts and that require the crucial examination of subjectivity of experience and thus lead researchers to begin inquiry from their research participants' point of view' (p. 134).

Grounded theory is therefore particularly well suited to counselling psychology and psychotherapy research, given its focus on processes, actions and meanings (Charmaz, 2006, 2008; Morrow, Castaneda-Sound & Abrahams, 2012).

According to counselling psychologists Strawbridge and Woolfe (2003) constructivist grounded theory mirrors the processes of counselling and reflects the emphasis counselling psychology places upon negotiating perceptions, 'without assuming an objectively observable truth' (p.8). According to Burck, (2005) the recursive and iterative process of grounded theory also fits with an enquiry into therapy, in which feedback informs and shapes further enquiry. Grounded theory is therefore considered useful for exploring how processes occur, the factors which are constructed as influencing these processes, and the strategies employed to manage them (Cresswell, 2007). Grounded theory was therefore considered to be a good fit with the research question, the aims of the study and due to the absence of research into the processes involved in the development of countertransference awareness and the therapeutic relationship.

Method & Procedure

Research Design

This is a qualitative study using a social constructionist methodology and a constructivist grounded theory method of data collection and analysis of 15 semi-structured interviews.

Participants

15 therapists were interviewed [see Appendix A for demographics table] in total, 4 of 15 interviews were conducted via Skype. 3 of the 15 participants were male, 4 psychotherapists, 1 psychologist, 4 CBT therapists, 3 integrative counsellors, 3 supervisors; 2 of which psychodynamic therapists and an integrative counsellor. 4 of the qualified therapists were also training to be counselling psychologists.

Recruitment

Sampling strategy:

An initial purposive sample of 12 therapists was recruited; in accordance with the constructivist grounded theory method, a further 3 participants were later recruited using a theoretical sampling strategy. Theoretical sampling is a method of sampling data which enables specific populations to be targeted and interview schedules to be modified to gain greater depth and understanding of the developing grounded theory, while checking, elaborating the boundaries and relationships among categories (Charmaz, 2006, 2008).

Adopting theoretical sampling, therefore, enabled the developing pathways categories and processes, to be examined and expanded by the inclusion of:

1. Those who had qualified in the last year to capture development over time, [2 participants]
2. Therapists who were not working with countertransference awareness explicitly to further develop the pathways under construction [2 participants]
3. Supervisors, to explore supervisor's perceptions of the development of countertransference awareness [3 participants]

Within the literature there are multiple recommendations for sample sizes within qualitative research, ranging from the research question to be addressed, the methodology adopted, the richness of the data collected, as well as potential barriers encountered, such as access to participants, researcher resources and time constraints (Adler & Adler, 1987; Charmaz, 2008; Flick, 2008). According to Burmeister and Aitken (2012) samples sizes are less about numbers per se and more about the depth of the data. In a constructivist grounded theory study, the focus is on developing thick and rich descriptions, sampling is therefore guided by whether the categories have reached theoretical sufficiency, discussed below.

***Inclusion criteria**:*

Participants recruited to the study needed to be appropriately qualified and accredited therapists, with at least one year's clinical experience of working one-to-one with clients, to explore the development of countertransference awareness over time. For this reason, only participants with some awareness of the construct of countertransference were recruited to the study.

Exclusion criteria. There were no explicit exclusion criteria.

Information regarding the study was posted on the following sites:

1. The British Psychological Society (BPS) Division of Counselling Psychology (DCOP), website and eLetter,
2. Facebook pages; Counselling Psychology, Counselling and Psychotherapy,
3. JISCMAIL a free online email database for various groups, including, counsellor's network, counselling and psychotherapy network, counselling research network,
4. Researchers own professional network, including, LinkedIn, a free professional networking site, groups included counselling and psychotherapy research and counselling psychology

Participants who expressed an interest in taking part were sent an information sheet with further details about the project [see Appendix B for information sheet] and a consent form, [see Appendix C for consent form]. Time, date and location of the interviews were then agreed via email.

Development of the Research Question

Careful conceptualisation and structuring of the research question is of high importance, as this will provide the direction and the boundaries for the entire research process (O'Leary, 2004; Evans, 2007). Clarke & Braun (2013) identify three types of research questions that will be asked:

1. The research question, which focuses on what it is the study wants to find out
2. The questions that are developed to gather data from the participants
3. The questions that are asked of the data to answer the initial research question.

The research question in the current study was broadly focused to capture the phenomenon of interest. It was an open question to avoid making assumptions about the direction or outcome of the research process. Interviews were semi-structured using open ended questions to ensure the discussions were centered upon the topic of interest, and open, non-judgmental and broad enough to enable detailed rich discussion, statements and stories to emerge regarding participant's subjective experiences (Charmaz, 2006).

The Research Interview

Interviews are a popular method of data collection in qualitative studies, which enable the in-depth exploration of a topic with individuals who have had the relevant experience of the topic under investigation (Hancock, Ockleford & Windridge, 2008). The semi-structured interview allows for fluidity, whilst still ensuring the themes of the study are explored (Hancock, Ockleford & Windridge, 2008). Charmaz (2006) states that intensive qualitative interviewing fits with Grounded Theory Method particularly well since both are potentially' open-ended yet directed', 'shaped yet emergent' and 'paced yet unrestricted' (p.28).

Open questions are those that provide broad parameters within which interviewees can formulate answers in their own words concerning topics specified by the interviewer (Roulston, 2010). These descriptions can be further explored when the interviewer follows up on what has already been said by asking further open-ended follow up questions, or 'probes' that incorporate the interviewee's words (Roulston, 2010). I drew upon my therapeutic skills during the research process to develop a rapport with my clients. Gemignani (2011) suggests that the rapport created by the researcher can have a significant impact on facilitating either a positive engagement or a negative engagement, and being aware of this will inform the research process. This helped me to ensure that rapport was built during the interview and at points of contact before and after the interview.

According to Berger (2015), the contextual factors of the researcher can affect participants' willingness to divulge and explore sensitive topics, with participants more likely to share their experiences with a researcher who they may feel is sympathetic to their situation. The fact that some of the participants felt able to share, very candidly aspects about themselves and their work, which at times did not show them in such a good light, would seem to support this.

In the initial interviews, participants were asked 5 open-ended questions [see Appendix E for interview questions used in the study]. In accordance with the constructivist grounded theory method, an additional question was later added to help with the developing analysis. As the analysis developed further a theoretical sampling strategy was adopted to refine the developing categories. Newly qualified therapists and clinical supervisors were therefore recruited.

The research setting

The research interviews were primarily carried out face to face in a location agreed with participants, including their place of work, place of study and their own home. Skype interview was offered an alternative of to provide participants with a choice and to widen the participant pool; these interviews were carried out via the computer in a private location. Skype has been identified as a viable alternative method of data collection for the research interview (Hanna, 2012; Hamilton & Bowers, 2006; Sullivan, 2012). The use of skype in the present study is discussed further in the evaluation section of the thesis below.

The interview process

Interviews lasted up to one hour and were audio recorded. The interviews were transcribed from the audio recording with all identifying material being removed at the point of transcription. Both the audio recording and transcript were saved onto a password, protected computer and the original recording deleted.

Data Analysis

Data analysis followed the procedures of the GT method outlined by Charmaz (2006, 2008, 2011) as outlined below:

Coding

Coding is the most fundamental and basic process in grounded theory which asks questions of the data to both understand the topic and guide subsequent data collection (Willig, 2001). According to Charmaz (2006) coding generates the 'bones' of the analysis; codes separate, organise and label what is happening in the data, which is she argues is a pivotal step in the development of a grounded theory. Open coding, also known as line-by-line coding, provides a good starting point to identify initial phenomena; conceptual labels are attached to almost every line in the interview transcript using the gerund to capture the actions and processes involved. As a result, the labels/terms used describe the underlying data and evoke meanings and actions (Alemu, Stevens, Ross & Chandler, 2015).

I adopted Charmaz's (2006, p.50-51) method to open coding by:

- Remaining open and staying close to the data
- Constructing short, simple and precise codes
- Comparing data with data
- Moving quickly through the data
- Using the gerund to identify processes and sequences in the data, preserving participant's actions. The gerund is the form of the verb that functions as a noun; it preserves action by stating what people are doing and so builds actions into the data which enables the identification of processes, e.g. 'reflect*ing'* 'hid*ing'* 'engag*ing'*

I also used questions developed by Charmaz (2006) to identify the actions and processes within the data (p.51-52):

- What does the data suggest? From whose point of view?
- What process is an issue here? How can it be defined?
- How does the process develop?
- How does the participant act while involved in this process?
- When, why, how does the process change?
- What are the consequences of the process?

Following transcription, I created a table in a Microsoft word document with 2 columns, one with the transcribed data and one to record the open codes [see Appendix K for transcript with examples of open coding]. Initially, to enable me to move quickly through the data, I applied provisional codes with the understanding that I could revise them later. In the later stages of the analysis these codes were checked and some were modified to ensure the codes were more nuanced capturing the process and sequences in the data.

The next coding phase is more abstract than open coding and known as focused coding. Focused codes are applied to several lines or paragraphs in a transcript and require the researcher to choose the most telling codes to represent the participant's voice. Focused codes move beyond the descriptive to a higher level of abstraction and enable the researcher to conceptualise what is taking place in the data by looking for relationships and patterns between code and identifying reoccurring concepts constructed from the data. I added a second column to the transcription table in the Microsoft word document, to record the focused codes, these were naturally longer codes, as they needed to capture more of the process [see Appendix K for transcript with examples of focused coding]. Like with the open codes, these were revised on subsequent readings to ensure they had moved beyond the descriptive; and that all the relationships and patterns had been captured.

Constant Comparison

Part of the process of concurrent data collection and analysis is constant comparison, which is the process by which codes, categories and incidents are compared with each other, which enables the data to be scrutinised, refined and conceptualised (Charmaz, 2008; McLeod, 2007). Charmaz (2006) suggests that using the comparative method, ideas can be tested out further refining the analysis; this process continues until a grounded theory is fully integrated (Birks & Mills, 2011). Comparing my codes initially helped me to develop tentative categories, which enabled me to identify commonalities and idiosyncrasies in my data and to further refine my theorising about the categories I was constructing. I initially printed out all the focused codes and separated them into groups. This enabled me to group codes with similar codes, which was the first step in developing tentative categories. I then transferred the grouped codes onto a Microsoft Excel spreadsheet [see Appendix F for example of a table compiled in excel], which then enabled me to move codes around more readily, identifying patterns and refining the analysis. The tentative identification of two distinct pathways, one reflective and one defensive, led me to ask further questions of my data, by the re-examination of the data and codes. This process was also instrumental in identifying potential avenues for theoretical sampling.

Memos

Memos are written records of the researcher's thinking during the process of undertaking a grounded theory study. As such, they vary in subject, intensity, coherence, theoretical content and usefulness to the finished product (Birks & Mills, 2011). Throughout the whole process, memos were made to capture ideas, theoretical links, relationships, differences and responses to the data and the codes. Memo writing was a continual process, which enabled the relationships between the categories and the different pathways I was constructing to develop. I wrote my memos in several dedicated journal books and on the transcript when transcribing the data. Memos enabled me to track my ideas about the data, which I could return to when developing the analysis.

My memos included quotes, references and theoretical ideas about pathways and categories, as well as ideas for further sampling [see Appendix G for an example of a memo]

The Literature Review

In classical grounded theory research, researchers are discouraged from conducting a literature review before data collection and analysis. Research author Dey (1999) however draws the distinction between ‘open mind and empty head’, suggesting that existing frameworks act as guides to examine the data (p.251). Similarly, Charmaz (2006) suggests that the literature can be used to help clarify ideas, to make comparisons and to further theoretical discussion (Charmaz, 2006). Consulting the literature during the analysis phase enabled different questions to be asked of the data, which helped to develop both the analysis and the theory under construction. By treating the theoretical literature as further data, I remained open and reflective on theoretical ideas, comparing and contrasting literature with literature.

Diagramming

An increasing number of grounded theorists use diagramming to integrate their ideas and to establish the logic of their ordering (Charmaz, 2006). It is a way of visualising both the content and the direction of the analysis by depicting the different categories, their properties and their relationships with one another (Charmaz, 2006). The diagram was a way of mapping the process; it helped me to identify pathways, directions and gaps by stimulating further questions to ask of the data, which in turn helped to develop and refine my categories. I mapped the diagram in a Microsoft word document, creating boxes, with category headings and short descriptive text [see Appendix H for an example of an early process diagram]. The diagram was instrumental in refining the analysis and as well as identifying gaps and questions, which was also key in identifying areas for theoretical sampling.

Theoretical sufficiency

Theoretical saturation is said to occur when new data no longer leads to new theoretical insights, however, the notion of saturation and whether this is achievable has been challenged (Dey, 1999). According to Dey (1999), because grounded theory does not code all the data, and adopts a theoretical sampling strategy, theoretical saturation is an 'imprecise term' (p257). Therefore, because coding is always partial and the sampling strategy focuses data collection in a particular area, Dey suggests that the term 'theoretical sufficiency' is more appropriate. Theoretical sufficiency was considered to be reached when the pre-existing categories were sufficient to capture the new data obtained through further sampling and analysis. This then led on to the final sort of the data.

Member Checking

Member checking is both a validity check and a 'way of finding out whether the data analysis is congruent with participants' experiences' (Curtin & Fossey, 2007, p. 92). Five participants were contacted and asked if they could comment on the process diagram; all confirmed that the process I had constructed was an accurate reflection of their experiences [see Appendix I for copy of participants replies]

Ethical considerations

The study was given Ethical approval by the University of the West of England Research & Governance board. Participants were informed at the outset about the potential risks of taking part. These are outlined in the Participant Information Sheet, which can be found in the Appendices [Appendix B]. Participants were informed that the nature of the topic being explored could be potentially distressing and therefore the contact details were made available of organisations where they could access support.

Contact details of sources of support were also provided on the debrief form [Appendix D]. Participants completed a consent form [Appendix C] prior to the arrangement of the interview after they had read the information sheet; consent was also confirmed on the day of the interview. Participants were informed they had the right to withdraw from the study without giving a reason, which they could do by contacting the researcher and quoting their unique ID number. Participants were also made aware that at the point of publication they would no longer be able to withdraw their data from the study. Participants were made aware of the limits of confidentiality prior to the interview, all participants were aware of the researcher's ethical obligations to divulge any concerns about the risk to clients or evidence of unethical clinical practice, in-line with the BPS codes of conduct.

Data Protection

Each participant was provided with a unique identifying number at the time of recruitment, which was added to the information sheet, consent sheet and demographics sheet. Participants Confidentiality was maintained by anonymising their interview material when transcribing the audio files. Any identifiable material was kept either on a password-protected computer or in locked files which only the researcher had access to. A key linking the names to the data was kept separate from the anonymised data in a password, protected file.
This was important in the likelihood of participants withdrawing from the study after the interview their transcripts needed to be identifiable to the researcher. The anonymised interview transcripts were printed for data analysis and the data backed up onto a USB stick as an extra precaution; these were also kept in the locked file. All email correspondence was deleted from the researcher's email inbox. Only anonymised data was shared with the research supervisors or used with participant's consent within the final write up of the study.

Reflexivity

Reflexivity is the process of reflecting critically on the self as the researcher (Kacen & Chaitin, 2006) by turning the lens back on oneself and thereby becoming aware of one's own place and influence on the whole research process (Berger, 2015). Research authors Kacen and Chaitin (2006), suggest that the researcher's worldview and background will shape and influence all aspects of the study, and therefore the research process is not an objective and independent process. Gemignani (2011) describes this as a place of 'relational' enquiry; the researcher cannot be separated from the participants and the theoretical knowledge, which enabled the possibility of enquiry in the first place.

As a relational trainee counselling psychologist, this reflexive way of understanding and engaging in the research process feels intuitively right; it mirrors the way I work with my clients in practice and therefore felt not only comfortable but ethical. One strategy to facilitate reflexivity is the keeping of a self-reflective journal to capture personal assumptions, biases and goals, making them more available for reflection and scrutiny (Etherington, 2004, 2001; Ortlipp, 2014). Furthermore, it is a place where thoughts, feelings and responses can be shared without inhibition (Etherington, 2004, 2001). My journal helped to keep me alert to my biases, as well as my ideas; to missed opportunities or stories not yet told. It also charted my growth both, as a person and as a researcher, highlighting how much I moved away from a position of safety to one, which could tolerate uncertainty and ambiguity.

The reason I chose this research topic was because I wanted to learn more about the construct of countertransference; my experience in this area was becoming a big part of my work. I had a psychodynamic supervisor who helped me to consider my clients in a different way and this stimulated my interest in the topic. According to Kacen and Chaitin (2006), the researcher being part of the context they are studying creates both advantages and disadvantages.

One advantage they suggest is the ‘insider’ position; the researcher is already familiar with the context, its language and symbols. This was certainly the case in the present study, as a therapist researching therapists, I held an insider position, which meant the dialogue between myself and my participants was from the outset based on an implicit understanding that we shared a familiar knowledge, role and context.

Kacen and Chaitin (2006) suggest that prior knowledge of the research context may be a disadvantage to the researcher as this may cause them to miss valuable insights. I became aware increasingly aware that I felt drawn to certain parts of the transcripts and not others in the initial stages of my analysis. On returning to the transcripts, I discovered material, which previously I had not noticed. Kacen and Chaitin (2006) suggest that managing this tension requires the researcher to get ‘close enough’ to study the context of choice, yet ‘far enough’ to be open to more nuanced aspects of the inquiry. This mirrors my therapeutic work where achieving an optimal distance between engagement and reflection needs constant attention and management, particularly concerning countertransferential material.

Holmes (2014) suggests attending to countertransference is as important during research as is it in therapy; both researcher and participant may experience unexpected thoughts and response and paying attention to these may be informative for the research process. To make these feelings useful, however, Holmes argues they need to be subjected to reflexive consideration. This has been an essential part of the research process for me as it has enabled me to both reflect and manage my countertransference responses to my participants (I was aware that I found it easier to build rapport with some participants more than others) to enable an open stance during all stages of the analysis. I am also aware that I hold biases and that I believe that attention to countertransference in the work is important and an essential source of information on the client-therapist relationship.

I am also aware that I privilege relational approaches to therapy. Being aware of my biases, I could observe and note my responses and attempt to minimise their impact on the research process. I was also aware that I was shocked at times at how unaware some participants seemed to be of their acting out of their countertransference, which served to challenge my assumption, that as a therapist you would always be aware of your own behaviour and its impact.

Another interesting reflection is how much my own experience of doing research mirrored the data. Having not done anything on this scale before, I did not have any experience to draw upon, which at times made the whole process feel overwhelming. To say I became defensive would be putting it mildly: 'I choose the wrong topic', I would say, 'other topics would have been easier', or 'I should have done a thematic analysis, it would be done by now'. When I acted out my distress, interestingly like my participants, I managed this by seeking out containment from the research team, by arranging tutorials or sending in my latest coding. The data mirroring my own experience was at times a bit confusing, as it left me concerned I was looking for my own experience in the data or that my own biases were having an impact. An example of this would be when I first tentatively mapped the categories on containment; I ended up disregarding them as I thought I was seeing my own experience in the data. As the analysis developed I could separate out my own experience to a greater degree, and see the parallels between my being a novice researcher and my participants accounts of being a novice therapist. Rigorously following the steps of the grounded theory method helped me to ensure that the theory I was constructing remained, as far as possible, grounded in the data, as well as helping me to monitor and reflect on my biases and potential blind spots.

Results and analysis

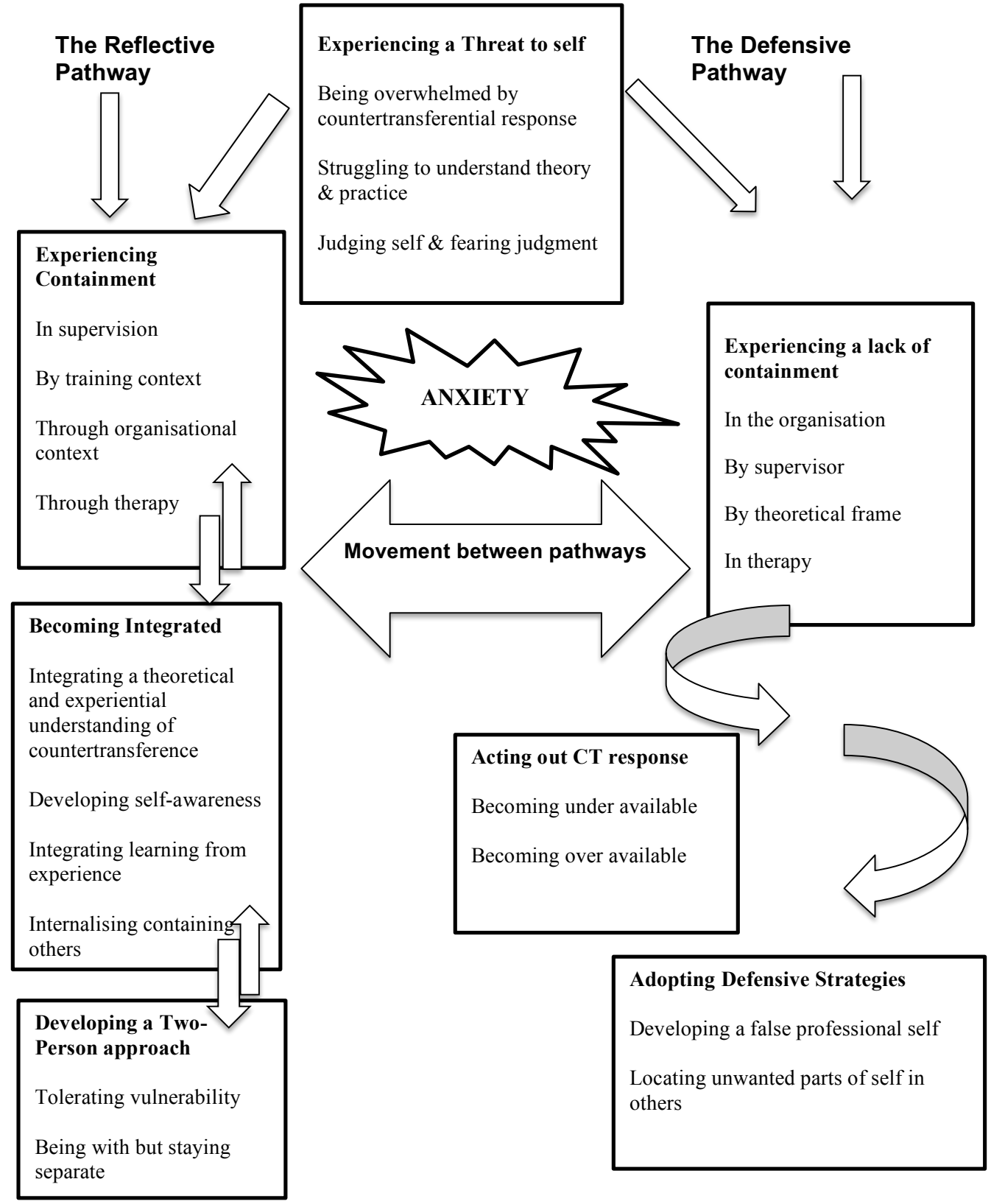
The grounded theory constructed from the data describes the development of countertransference awareness in therapists and the ways in which this was understood to influence the therapeutic relationship [see Fig.1 below for the diagram of process]. Participants described several *threats to self,* in the early stages of this process including feeling *overwhelmed by their countertransferential responses* in their work with clients, as they *struggled to understand theory and practice* while training. A further threat to the self was experienced through countertransference feelings and responses being constructed by participants as a sign of professional incompetence. If these anxieties remained uncontained by the organisation, in supervision, in personal therapy and by their theoretical framework, participants appeared to adopt defensive strategies, as a way of hiding their perceived incompetence and vulnerabilities, through either the *adoption of a false self* or by *locating unwanted parts of self in others*. Without the containing structure in place to develop their awareness of countertransference, some participants unwittingly *acted out their countertransference response* in the client-therapist relationship. For some, this had a negative effect on the therapeutic relationship, with some relationship either becoming stuck or ending prematurely as participants either became *under available* or *over available.* Because of working within organisational cultures that also failed to offer containment, participants found there was little opportunity to reflect on the work and therefore there was little opportunity to revise their defensive strategies, manage their anxiety, and learn from experience and therapeutic enactments.

Conversely, if these anxieties were contained, participants began to follow a more reflective pathway developing their own reflective capabilities and their countertransference awareness through the *experience of containment, in supervision, in training, in an organisational context and in therapy*.

The experience of containment enabled participant to move away from feelings of incompetence, as they began to develop a framework which helped them to develop and make sense of their countertransferential feelings and responses. This lead to a greater sense of integration of their theoretical and experiential understanding of countertransference, and their learning from experience, which supported and facilitated their growing awareness of their own personal dynamics, which helped to develop their self-awareness. Over time a small number of participants began to reflect in the moment, as they internalised containing others, who were supporting their developing countertransference and self-awareness. Participants began to move towards *developing a two-person approach*, which enabled some participants to *tolerate vulnerability*, the anxiety inherent in the work, which they could now consider as they were able to retain a separate sense of self, by *being with but staying separate*. As a result, participants could engage more fully in the therapeutic relationship.

Movement between the two pathways seemed to occur primarily when there was a change in containment or when participants re-experienced threats to self.

Fig 1: Process diagram of grounded theory of countertransference awareness development and the Therapeutic Relationship



Experiencing a Threat to self

Participants described the threats to the self-involved in the early stages of their therapy training; these were experienced as threats both to their personal and professional sense of self and led to high levels of anxiety. For many participants, the reality of client work was somewhat different to participants' expectations; Participants described feeling overwhelmed, both by what was evoked in them by their client work, and by their struggles to understand both theory and practice. A further threat was experienced by the process of engaging in a high level of self-scrutiny, which left them feeling inadequate and incompetent. Participants also feared the scrutiny of others believing that this would expose their vulnerabilities and confirm that they were unsuitable for the task of training to become a therapist. Experiencing a threat to self therefore compromises the sub categories, *being overwhelmed by countertransference response, struggling to understand theory and practice*, and *judging self and fearing judgement.*

1.1 Being overwhelmed by countertransferential response

Participants described feeling unprepared for the emotional responses that the client material and the client could evoke in in them. Lacking either a theoretical or an experiential understanding of countertransference at the outset of their training, participants were understandably ill equipped to cope with remaining present and responsive to their clients, while regulating and reflecting on their own responses in the therapeutic relationship. In the absence of a framework for processing these experiences, participants were left feeling emotionally overwhelmed:

"I was very self-conscious and very new to it all and I wasn't very sure what I was doing ...He had this enormous sense of power about what he was saying and I felt very frightened at the time" Participant 1 [female, psychologist working in private practice].

"It was quite scary I remember her being quite, not her being but the work being quite scary in terms of it being my first sort of experience… I probably shouldn't of [sic] worked with her because there was an awful lot going on that perhaps I didn't understand, I didn't have experience with" Participant 3 [female, psychotherapist working in CAMHS service].

"I felt pulled to him and I felt really bad, I thought I'm being really unprofessional, you know having some kind of feelings for someone" Participant 2 [female, psychological therapist & trainee counselling psychologist working in the NHS].

Feelings of confusion, uncertainty and doubt added to the sense of overwhelm:

"Because of certain similarities in our background it was, she was very, it was incredibly difficult for me to ascertain, and I had her quite early on in my experience, um ascertain what exactly was going on in the room" Participant 10 [female, psychotherapist working in private practice].

"I got into quite a tangle at the time because when I was younger I was scared of anger... I got confused with my fear of her anger. So again, the spotlight was on me, oh dear it's my problem with anger" Participant 8 [female, counsellor and psychotherapist working within a university counselling service].

1.2 Struggling to understand theory and practice

While the lack of a theoretical understanding of countertransference meant that participants struggled to make sense of their responses to their clients, being introduced to the theoretical construct of countertransference in advance of working with clients was experienced as similarly problematic.

Countertransference appeared to be a difficult concept to understand theoretically without an experiential understanding of the phenomena; without experience, awareness of the construct remained at a purely intellectual level and therefore was hard to assimilate leading to further anxieties and self-criticism:

When I first first, first started… I didn't even understand what it was, I remember writing my essay on transference, my tutor writing something like, I'm not quite sure you've understood this…I remember feeling quite stupid because it's so fundamental to the work and I don't understand it" Participant 9 [female, integrative psychotherapist working in private practice].

"When you first train and you kind of get in a room with a client and you know your there with your theories and you know when you first start out basically it can be really difficult until you get enough clinical experience to sort of understand situations" Participant 3 [female, psychotherapist working in CAMHS service].

The theory of countertransference did not initially help participants; they struggled to make sense of what the theory meant, and therefore were unable to apply it to practice:

"I was very self-conscious and very new to it all and I wasn't very sure what I was doing..…. I didn't know how to use it. I knew what countertransference was and I was trying to be aware of it but I wasn't yet properly aware of it" Participant 1 [female, psychologist working in private practice]

1.3 Judging Self and Fearing Judgment

Participants in training appeared to be striving towards an idealised image of the competent professional therapist, whom they believed would not experience negative feelings towards their clients or respond unhelpfully.
When participant's vulnerabilities were evoked in the work, this led some to judge themselves against this idealised standard; negative responses and feelings towards clients were constructed as an indication of personal failings and incompetence, rather than reflected on as part of the work:

"I think when I first started it was all about me (laughter) it was like I'm feeling this because I'm inadequate because I'm I've not had enough therapy because I think I had this kind of view that there was a perfect therapist out there and I wasn't it" Participant 8 [female, counsellor and psychotherapist working within a university counseling service].

These judgements also appeared to be projected onto supervisors, clients and teachers; many participants expressed fears that they would be considered incompetent and therefore unsuitable for the role of a therapist:

"She [supervisor] would always ask me questions that I hadn't thought about, hadn't asked the clients, so I kind of of thought am I doing something wrong here" Participant 2 [female, psychological therapist and trainee counselling psychologist working in the NHS].

"I would struggle with saying I didn't like people very much…as it would feel too revealing, I didn't want to look weak, I didn't want to look like the therapist in training, who hadn't sorted her own stuff" Participant 9 [female, integrative psychotherapist working in private practice].

The Reflective Pathway

As participants progressed through their training they began to follow one of two pathways, a reflective pathway or what appeared to be a more defensive pathway. The pathway followed appeared to be dependent on whether a containing framework was in place to provide the space and time to reflect on countertransferential responses. Containment offered the possibility for self-development, whereas, a lack of containment appeared to lead to self-protection. As participants began to develop their countertransferential awareness they began to reflect on the therapeutic relationship; the client's material and their own. The capacity to reflect on these experiences appeared to be critical in developing awareness of the client-therapist dynamics, as well as increasing the therapist's self-awareness and ego strength. Furthermore, the opportunity to consider the causes of their anxiety enabled participants to understand their responses in a new light, which helped them to move away from a sense of incompetence and to develop realistic expectations of themselves and the work.

As participants began to consider the relationship though this framework, they became more able to reflect on the inter-subjective field and develop a two-person approach to the work. While participants experienced clinical work as deeply uncomfortable at times, their developing countertransference awareness increased their ability to remain present for their clients. Participants shifted from the need to defend against discomfort to trying to unpick and understand their experience. Given that the capacity to reflect on the work was a critical component, remaining on the reflective pathway was therefore reliant on participant's ability to reflect upon their countertransference awareness.

The reflective pathway compromises the categories of, *experiencing containment, becoming integrated and developing a two-person approach to the work.*

Experiencing containment

For some participants, the threats to self-inherent in the training began to diminish if they experienced containment in supervision, in their training organisations, their organisational contexts and their personal therapy. Participant's experiences became normalised through reflection and the assimilation of a shared theoretical framework, which offered a shared philosophy and a common language, which offered an alternative understanding for what they were experiencing; the first step in their development of countertransferential awareness.

2.1 In Supervision

The supervisor's response to the sharing of clinical material seemed to be critical in enabling participants to experience supervision as a supportive, safe and trusting space; one where they didn't fear judgment. The supervisor's attitude of intellectual curiosity, and the provision of a space, where countertransferential material could be explored, considered anew and made sense of, helped participants to begin to construct clinical material, including their countertransferential responses, from a different perspective. The supervisor's response seemed to stimulate participant's interest in, and curiosity about, their own responses, enabling them to develop both their emotional and intellectual awareness and bridging the gap between theory and practice:

*"They've been intellectually curious…non-judgmental curiosity…a playfulness to it…I think it's about being able to trust the person to meet me with whatever I bring "*Participant 8 [female, counsellor and psychotherapist working within a university counselling service].

"This sense that not only that I should take everything but I can…… it's that feeling of being held and supported. At the same time, it's a feeling on my part I want to know" Participant 10 [female, integrative counsellor working in private practice].

Through an experience of supervision as both, a holding and containing environment, which normalised and validated their experiences, participants began to move away from a position of shame, defensiveness and incompetence and the defensive need to demonstrate 'competence' in supervision. As a result, participants began to feel more resilient in the work:

"I was really embarrassed to take it there but at the same time I had to, because I was feeling really bad about it…… by actually talking about it and kind of understanding what was going on it could I could then change, I could see it in a different way. I didn't feel embarrassed as I understood it... I didn't feel like I was being unprofessional" Participant 2 [female, psychological therapist & trainee counselling psychologist working in the NHS].

"Had I not, had I been embarrassed by it or ashamed to put that in front of my supervisor look what you would be missing out on…. You know in the service of my client. I be busy punishing myself and being almost unnaturally reactive in a sense to try and guard against" Participant 10 [female, integrative counsellor working in private practice].

2.2 By the training context

Training contexts which privileged an attendance to countertransference, were recognised as an important part in developing countertransference awareness; these offered both a guiding framework and opportunities for reflection:

"I was sort of introduced quite early on in my therapy training...it was keen on sort of inter-subjective ideas…there are two people in the room and they bring with them everything that's gone before" Participant 4 [female, psychotherapist working in private practice].

"I trained in the analytical tradition so obviously, countertransference and increasing awareness and development of countertransference attunement was a cornerstone of that training, so I would say that um by virtue of my training countertransference has become one of the key aspects of my practice" Participant 5 [female, psychodynamic therapist working in a university setting].

Participants described how the provision of a culture where attendance to countertransference was encouraged, normalised and valued, promoted the development of self-awareness and reflective skills, which encouraged participants to observe and reflect on their emotional responses towards both themselves and their clients:

"It was very much based on quite specific kind of questions directed towards me about how I felt about being in sessions with clients and it was those kinds of introspective questions that got me to think about it" Participant 2 [female, psychological therapist and trainee counselling psychologist working in the NHS].

"In skills practice where we just paired up with other trainees trying it out so in that safe place of well I'm just wondering if this is going on it makes you bolder you know ….so you can try those responses out and the more you do that the more again the confidence builds and you think I can trust my own instinctive responses" Participant 4 [female, psychotherapist working in private practice].

Peer support was an important part of this process as it enabled a mutual sharing of experiences as well as a shared language, which helped to normalise and ameliorate anxiety and feelings of inadequacy that could arise in the work. This indicated that peers could offer a compensatory safe space, where the more difficult aspects of the work could be shared and understood, supporting the participant's approach to the work:

"I will take to my peers because we are probably a bit more open and relaxed to admit I mean especially the real negative reactions and its really useful…. where you take it those countertransferential responses is really important because you have to trust that they're going to be heard without judgement" Participant 4 [female, psychotherapist working in private practice].

2.3 Through the organisational context

Some participants worked in contexts where attendance to countertransferential material was part of the organisational culture; this created an expectation and requirement to participate in reflective practice. In this way attendance to countertransference began to be constructed as part of the work; not only acceptable but expected:

"I work at UCL in our clinical meeting we have once a week clinical meeting and we use the Balint method as a way to think about client, um try to see what comes up from, you know different people and we think we are picking up different things" Participant 5 [female, psychodynamic psychotherapist working within a university counselling service]

"I think because I work with a bunch of therapists as well were always kind of discussing those kinds of things. So, it's kind of an on-going process really, I think. It doesn't just happen a set allotted time when I have my supervision, it happens over many different conversations with various people. Participant 3 [female, psychotherapist working in CAMHS service]

2.4 Through Therapy

Many participants described how their personal therapy offered a space for reflection leading to an increased understanding of their own dynamics and to increased self-acceptance.

Developing self-awareness in this way enabled some participants to become more able to reflect on their countertransference responses and to recognise and separate out their own material from that of their clients, instead of locating this material within their clients:

"That need for the aside from any of the training to have the therapeutic work on yourself so you know what own material is and then you can join up the dots…I think if you haven't had that therapeutic experience you won't be able to join up those dots" Participant 4 [female, psychotherapist working in private practice].

"I have maintained a space for um personal therapy, coupled with increasing awareness of you know my own dynamics, I think this has, I feel have been able to use it in more you now hopefully informative and refined way" Participant 5 [female, psychodynamic therapist working in a university setting].

"I don't really think the training course covered CT enough and I became aware of it more in my personal therapy. I have to say my appreciation, more through personal therapy, has brought an appreciation of the approach, where it can be really really useful" Participant 7 [male, integrative therapist and trainee counselling psychologist].

Becoming integrated

Containment in these domains increased the capacity for both self-reflection and reflection on the work for some participants, leading to greater integration, both intra-psychically and professionally. Participant's ability to make connections between theory and experience, seemed to give them more confidence in the work, as well as fostering greater resilience and a capacity to engage in honest reflection.

As participant's self-awareness and emotional resilience developed through training, supervision, personal therapy and clinical work, they became more able to accept reflect on and accept previously disowned parts of the self, which they had associated with incompetence, which further increased their capacity to engage in honest non-defensive reflection and their capacity for relationship. Becoming integrated compromises the sub-categories of *Integrating theoretical and experiential understanding of countertransference, developing self-awareness, integrating learning from experience and internalising containing others.*

3.1 Integrating theoretical and experiential understanding of countertransference

Participants described developing their understanding of countertransference when they connected their theoretical understanding with their clinical experience and could reflect on this. This process seemed more manageable when participants were not feeling overwhelmed by countertransferential material and were, therefore, more able to observe and reflect on their experience non-defensively. As theory and practice become more integrated, participants described how conceptual and experiential understandings, each support the comprehension of the other, as the intangible can be put into words and the theory put into practice:

"I think you can have all the theory you want and be an excellent academic but until you get into a room with a client none of that makes sense I don't think because it's about the relationship" Participant 3 [female, psychotherapist working in CAMHS service].

"It's a bit like I suppose teach children to be happy, actually they've got to experience it and then be helped to know what it is, for that experience to be given a name…I think countertransference is the same thing you have got to be be in it before you can take a step back and go ahh oh" Participant 12 [female, psychotherapist and supervisor working in the NHS mental health services and private practice].

Being able to integrate theoretical and experiential understandings of countertransference appeared to increase participant's capacity to pay attention to their experience in the room with their clients, as well as their curiosity about this experience. Participants could move away from constructing their countertransferential responses critically, towards understanding that these responses gave them access to information, about themselves, their clients, and the therapeutic relationship, which enhanced both their self-awareness and their understanding of the client:

"I think it can be a very difficult thing to engage with, you know what is it saying about me, and if you place a value on it…I'm good or bad... that leads to all sort self-abuse and that's really uncomfortable but it is, it kind of is what it is, and using and getting to the bottom of it there's nothing like self-exploration to enhance your skills as a counsellor, as all we've got its ourselves" Participant 10 [female, integrative counsellor working in private practice].

3.2 Developing Self-Awareness

Participants described how this process of increased awareness of their feelings, motivations and relational dynamics in their own therapy, in supervision and in their clinical work enabled them to change the way they approached the work. Increasing self-awareness facilitated a deeper level of insight, which increasingly enabled participants to differentiate between their own dynamics and those of the client, allowing them to become more available in their therapeutic relationships.

This development seemed to promote self-acceptance, resilience and a strengthened ego, enabling participants to integrate previously disowned parts of self, which they had previously defended against because of their sense of shame and inadequacy. Consequently, participants described feeling more equipped to manage their countertransferential material when it surfaced:

"my stuff is quieted down as it were but I know it's there its always going to be sensitive, I can then use myself as a barometer, I know what's going on so if I'm with someone who wants to dominate me I don't need to be dominated, but I can see that say hey that's going on I wonder why they might want to do that" Participant 11 [male, Psychotherapist, supervisor and trainer].

"I think over a period of time my awareness built up more into thinking about my responses and my physical feelings, my emotions and everything that went on with a client and how that kind of might impact my history, things that I have learnt over my childhood and slightly different things" Participant 2 [female, IAPT Psychological Therapist and Trainee Counselling Psychologist working in the NHS].

"You're constantly having to think what's happening for the client, what's happening for you and then kind of how those two link and what belongs to them, what belongs to you" Participant 3 [female, psychotherapist working in CAMHS service].

3.3 Integrating learning from experience

Participants commitment to, and engagement with, ongoing reflection opened the possibility of ongoing development and learning; their motivation to scrutinise their work and learn from the experience enabled them to develop their countertransference awareness retrospectively. Retrospective learning seemed to offer some distance, whereby participants could engage in an honest non-defensive reflection on their work, including that which was constructed as less successful:

"*See if I come across somebody now I can still have those same experiences and it still dredges up for me early experiences of being afraid and being powerless, or whatever. But I understand it so much more now so that when it happens with a client in a session I can talk with them about it"* Participant 1 [female, Psychologist working in private practice].

"Allowing yourself to be seen as fallible which again I think is I wouldn't of [sic] done in my first few years as a therapist I wouldn't of [sic] had the confidence to say well I got that wrong… now I much more willing to do that so that then makes you freer" Participant 4 [female, psychotherapist working in private practice].

The interview itself also appeared to offer some participants a reflective learning space, illustrated here by participant 2, who could consider the client material in a different way:

"I just wasn't aware of it I just felt empty and every time I took him to supervision I just couldn't get a feel of him in the room and its only now talking about it and afterwards that (laughter) maybe the helpless thing I was getting from him but yeah it was so strange I had no sense of that at all" [female, IAPT Psychological Therapist and Trainee Counselling Psychologist working in the NHS].

3.4 Internalising Containing Others

Over time some participant appeared to internalise and integrate their experiences of containment, which alongside their increased self-awareness, enabled them to work with more immediacy, becoming aware of their countertransference as it arose in the moment and making it available for more immediate reflection:

"I had supervisor who was really cool and sometimes I imagine him with me watching ...I find it helps because I literally visualise, this character on my shoulder, and it helps me kind of rein myself in a bit, when I want to go in a certain direction" Participant 7 [male, Integrative therapist and trainee counselling psychologist].

"Now I much more likely to say well this person really chimes with me, I carry that awareness more" Participant 9 [female, integrative psychotherapist working in private practice].

"For a number of years, I used to have to go away and think about it and then come back and do it, I couldn't do it in the moment, and that's come with maturity as a counsellor, psychotherapist and its matured with it" Participant 8 [female, counsellor and psychotherapist working within a university counselling service].

Developing a Two-person approach

Participants on the reflective pathway appeared to have moved from what appeared to be a one-person approach, where the focus was more on the client, to a two-person approach, whereby participants began to consider the client-therapist relationship and the intersubjective field. Attention was given to what was occurring in the space between client and therapist, and to how each could impact and influence the other and co-construct meaning. Countertransferential responses were understood to contain important information on the internal world of both the client and the therapist, a key component of which was the ability to reflect on the experience. This enabled participants to move away from defending against affect; to utilising their own experiences to inform the work as well as enabling them to fully engage and remain present. Developing a two-person approach compromises the sub-categories *tolerating vulnerability* and *being with but staying separate.*

4.1 Tolerating vulnerability

By becoming increasingly able to tolerate their own discomfort and vulnerability in supervision, therapy and in session, participants began to move away from judging themselves, towards a position where being able to tolerate the therapeutic experience and the vulnerability induced, was considered a critical part of the work and one which lead to increased insight and understanding. Participant's capacity to sit with vulnerability in the room, both the client's and their own, enabled them to attune to their clients, which allowed for a deeper understanding to develop in the therapeutic relationship:

"When is out of awareness I don't feel, I don't like this, it's just uncomfortable so you know there is something to be said for sitting with the discomfort, but also really trying to unravel it. I don't like being uncomfortable. So, unravelling it makes it more comfortable" Participant 10 [female, integrative counsellor working in private practice]

"I get more of an empathy trigger…I just see that this, this client in particular at the moment is really trying to, he's trying really hard, he's working really really hard… when he's criticising me about things, I think it just because he doesn't feel certain that it's going to work with me" Participant 9 [female, integrative psychotherapist working in private practice].

Tolerating their own vulnerability within the relationship also enabled participants to remain open to a two-way process. Having had their own experiences explored, validated and made sense of in supervision, therapy and in training, experiences which appeared to lead to increased ego strength, participants were increasingly able to respond non-defensively, which allowed them to validate their client's experience in the room:

"When it's going well and I'm open to it and I'm not defensive its really productive….I have to be um I have to re-prompt myself to be non-defensive about it and really own it and he can…He will just see my eyebrow twitch and say your disapproving, mm am I? Maybe I am a bit (laughter) being open to that two way process…if you can be non-defensive about that yeah you got some room for exploring stuff so if you shut it down and so oh my eyebrow does that (laughter) you're shutting off a road of enquiry" Participant 4 [female, psychotherapist working in private practice].

4.2 Being with but staying separate

Through the process of developing a theoretical framework, being contained and becoming increasingly self-aware and integrated, participants began to interpret their countertransferential responses in a way that helped them to remain therapeutically involved with the client, whilst also remaining sufficiently separate to think about the experience. Participants described becoming increasingly able to listen to their clients and to their own countertransferential responses simultaneously. This dual process was critical in helping participants to manage their own countertransferential responses:

"I think you have to be caught up in it, sometimes to understand it, you have to be in the experience, if you're not going to allow yourself to be caught up in it, you won't understand something…to be present in a different way… you're in a place where your thinking about it. It gives you a place within yourself feel separate from it". Participant 12 [female, psychotherapist and supervisor working in the NHS mental health services and private practice]

"I'm listening to how I feel, how I see the client responding to how I am and using that as a way of understanding better where it is that they're coming from" Participant 1 [female, psychologist working in private practice].

This increasing confidence enabled some participants to work less defensively. Furthermore, participants' increased interest in their own dynamics enabled them to separate out their own material from the clients.

"I want to mother everybody at the moment and I'm having to think that's about you, and this is not what he needs, so I'm holding back more and being boundaried and being warm, but I'm not doing what my urge is because that's for me…I had to catch myself and stop and go this isn't your therapy, this isn't yours" Participant 9 [female, integrative psychotherapist working in private practice].

"I don't take my clients into personal therapy, you know its myself but I get a better understanding of me and where this is coming from in my life and then sometimes it's a guide…I don't add to it because I know it's mine" Participant 7 [male, integrative therapist and trainee counselling psychologist].

Having sifted through the experience and separating out their material from the client's experience, participants were more able to offer the client an interpretation of an experience, which had been cognitively processed, which enabled the meaning to be reflected on rather than acted out:

"It actually probably took about 7-8 sessions...to kind of understand… I think she hooked into my a little bit of the people pleaser in me…For a while I think I was caught up in that and responding in countertransference and perhaps in a less productive way. Until I really sat and thought about it and spoke about it with my supervisor and went aah this is her this isn't me…I was able then to say to her sometimes it feel like nothing I do is good enough.. I'm wondering if this is something that you feel like exists in your life" Participant 3 [female, psychotherapist working in CAMHS service].

"I had to be very aware that my wanting to sort of like stop it wasn't necessarily healthy for the therapeutic relationship..there was a period of being what she needed me to be without colluding was important, that mother that could hold those projections and help her to ascertain where her boundaries were" Participant 10 [female, psychotherapist working in private practice].

The Defensive Pathway

In the absence of a containing other or framework to help them to understand what was being evoked in them by their clinical work, participants appeared to follow a defensive pathway; the focus here was less on understanding their countertransferential responses and more on managing what were sometimes overwhelming levels of anxiety through the adoption of defensive strategies. However, this lack of awareness led some participants to act out their countertransferential responses in the therapeutic relationship. These unconscious enactments further elevated their anxiety leading to an increasing need to protect themselves by becoming either over or under available for their clients, depending on what was evoked, strategies that impacted negatively on the therapeutic relationship. The defensive pathway compromises the categories of *experiencing a lack of containment, adopting defensive strategies* and *acting out countertransference response.*

Experiencing a lack of containment

Participant's accounts indicated four key areas where they experienced a lack of containment: contextual (both workplace and training organisation), in supervision, in therapy and in the lack of a theoretical frame. Participant's accounts suggest that unless there is a containing function in place they remained anxiously overwhelmed and at risk of continually defensively discharging or acting out in the therapeutic dyad.

The lack of opportunities afforded to participants to reflect upon their countertransference, appeared to prevent participants from fully developing their countertransference and their self-awareness, to the detriment of both the participant and the client.

5.1 In the organisation

Many participants described working in contexts and organisational cultures where they were expected to meet the demands of the organisation and follow guidelines on therapeutic practice, which they didn't always feel comfortable. The high-volume services that many the participants worked within, limited the space and time required to reflect on clinical practice; the adoption of defensive practice appeared to be a survival strategy. Even when participants were aware of having difficult feelings and responses to clients they didn't seem to have the time or motivation to reflect on these further and as a result insights into either the relationship, the client or their own dynamics remained unexplored. As a result, countertransferential responses remained unexplored and defended against; participants described working with clients in more of a superficial way, where the real issues were not attended to, either from a lack of awareness or from a lack confidence. Unlike those on the reflective pathway, those on the defensive pathway were more focused on self-protection than self-awareness:

"I think about it in terms of my practice and working in a service that's kind of high volume, and in that respect maybe not having massive amounts of time to reflect, make sense of things, process things from whatever perspective you're coming from. Therefore, to have that time to reflect if something's not sitting that comfortable with you or you've got a particularly strong reaction to a client you like them or why the next person you can't stand them in a way, may be irritable, there isn't necessarily the time to kind of process them from whatever perspective Participant 15 [male, CBT psychological therapist working within an NHS depression and anxiety service].

"working in contexts where you're being measured all the time like IAPT and stuff like that there's pressure, there's pressure to get it right all the time, so you would be less likely to trust your CT, when you've got a six session contract, and every session your being measured is the client getting better as you go along, am I going to get a good or bad report." Participant 11 [male, psychotherapist, supervisor and trainer].

Some participants identified that they found it difficult to know what contributed to a good or bad outcome in therapy; for many, the contexts that they were working privileged outcome measures over reflective practice. This seemed to limit participant's learning opportunities, leading to a lack awareness both of self and what facilities healing and growth within a therapeutic relationship.

"The thing is it's really difficult to tell...We use various outcomes and we get subjective feedback from the clients, and say whether that's worked well or hasn't worked well, but it's really difficult to work out well what bits of this that I did actually did make a difference and therefore whether I use the language CT or something more CBT, whether that was a sufficient way to manage CT, or actually I dealt with it in such an ignorant way that if I had dealt with it properly it might of had a big difference, it's really difficult to tell" Participant 15 [male, CBT psychological therapist working within NHS depression and anxiety service].

5.2 By Supervisor

For some participants, supervision was an extension of the organisational structure as supervisors worked within the same culture and therefore, faced similar pressures and demands. The supervisory space, therefore, mirrored the rigid organisational structure and was experienced as rigid and prescriptive, with a focus on following the model rather than on a consideration of interpersonal material arising in the relationship. This led to some participants feeling helpless, frustrated and stuck.

Furthermore, lack of containment in the organisation and in supervision meant that participants struggled to explore and make sense of what was being enacted. While some participants were aware that attention to relationship dynamics could be useful, they continued to comply with the supervisory and organisational approach to the work:

"I was trying to follow the depression model which was incredibly hard she was someone who was coming in and she was really quite hard to manage in the session….my supervisor again she was don't focus on the therapeutic relationship because that's not what we're going to focus on the CBT and the depression…I think if I was able to develop and the use the transference and countertransference it would of made quite a difference to her and her learning" [female, psychological therapist and trainee counselling psychologist working in the NHS].

For Participant 7, supervision didn't feel like a safe space to disclose his countertransference response as he was uncertain how such personal material would be received; therapist dynamics appeared to be considered a taboo topic. As a result, supervisees became increasingly defensive about what they brought to supervision foreclosing further exploration

"I spoke about addiction one time in um supervision, I can't say it wasn't well received or not, either way, it was like the energy in the room dropped and just sort of, I sort of you know I don't think I'm going to bring that one again...I had a feeling I don't know if this was right, um wasn't really what he wanted, how he wanted me to use supervision, my supervisor. So I now steered away from, which for me could be quite valuable insights" [male, integrative therapist and trainee counselling psychologist].

Participant 8, explained that her supervisor was more focused on telling her what to do, rather offering a space for reflection:

"I think my least helpful supervision has been supervisors who want to counsel...so say you should say this, why did you do that, why don't, there not in the room, so it's that kind of quite controlling that's not helpful" [female, counsellor and psychotherapist working within a university counseling service].

5.3 By theoretical frame

Theoretical frameworks, which didn't offer a way of making sense of countertransferential material, were experienced by some participants as uncontaining. Without a way of conceptualising their responses in a meaningful way, participants were understandably fearful of attending to them when they arose:

" It would feel very scary for me to go down there, I haven't got any theories that I can pin anything onto, if I haven't got a framework or a structure that I'm working within I would feel like I was in free fall really I haven't learnt it, I wasn't taught it, it wasn't the way I was taught, I was taught to follow" Participant 13 [female, psychological therapist and integrative counsellor working within an NHS setting and private practice].

Working within a theoretical framework which differed from that of their supervisor was also felt to be confusing for participants, particularly when their supervisor encouraged them to pay attention to countertransferential material. It would appear from participant's accounts that to make sense of countertransferential material, continuity between theoretical frameworks, organisational and supervisory focus was needed; otherwise, the construct remained at an abstract level and was therefore hard to assimilate:

"I'm ignorant of that approach because I'm just not trained in it, so it's very difficult for me, I can't relate to that material that thinking /feeling in that way…I didn't find it easy as I don't think I understood it that mixing of the sort of languages or the different perspectives that maybe sometimes seemed um I don't conflicting in a way, confusing I didn't know some of the language it was difficult I think…it was kind of difficult to understand and relate to it" Participant 15 [male, CBT psychological therapist working within an NHS depression and anxiety service].

5.4 In Therapy

Unlike the reflective pathway, where personal therapy was constructed as a way of reducing participant's vulnerability, for some participant's therapy made them feel more vulnerable and exposed. This resulted in participants appearing to adopt defensive strategies to distance themselves from their vulnerability and to contain the anxiety and overwhelm induced by the experience:

"I've had therapist who are staring at me and you make a little move and they say oh why, and I'm sorry fuck it, I'm just go away, I just feel it's so intrusive oh you uncrossed your legs, then what do you think that means, nothing... I'm thinking what I really want to talk about is that and you're bringing me over there" Participant 13 [female, psychological therapist and integrative counsellor, working within an NHS setting and private practice].

Participant 10, described how although she complied with the therapy by continuing to attend, even though she had disengaged emotionally:

"A therapist I saw on the course, and it was horrendous, and I stayed with her for the duration of the course and because I was so busy and couldn't bear the thought of having somebody else you know what it's like but also more importantly I thought it doesn't matter how how I become more familiar with myself or what these issues are but obviously I'm experiencing this as a rupture but what her stuff is doesn't matter, what really matters is how am I receiving this and what that's telling me about myself" [female, integrative counsellor working in private practice].

One participant described being caught up in, what sounded like an enactment with his therapist. Not being able to make sense of the therapist's behaviours, left the participant feeling more vulnerable and psychologically injured by the experience:

"I had counsellor storm out on me once...I've been thinking for years…what did I bring and what did he. I came to conclusion that he went way way outside of any therapeutic frame…I feel damaged by this personal incident, I unpack it in my own analysis, psychoanalysis, it's difficult. It was very painful, it really was" Participant 7 [male, integrative therapist and trainee-counselling psychologist].

Adopting Defensive Strategies

When containment and the opportunity to reflect on countertransferential material was lacking, participants appeared to manage their anxieties by resorting to defensive strategies, to keep what was experienced as potentially threatening, outside of awareness. Furthermore, when participants constructed their countertransferential responses as an indication of their incompetence, defensive strategies seemed to minimise this threat to the self.

6.1 Developing a False Professional Self

Participant's defensive need to maintain a sense of a professional competence appeared to lead to the development of a false professional self, as a way of keeping outside of awareness potential threats, which could expose or reveal vulnerability. In marked contrast to the contained participants who increasingly came to integrate disowned parts of themselves, uncontained participants, attempted to conceal aspects of self, which did not fit their idealised image of a competent professional therapist. This false professional self-appeared to be an attempt to hide responses and experiences, which participants feared might lead to criticism, from themselves and from others. This was particularly true in supervision, where participants edited and withheld material, which they felt could show them in a bad light. This defensive strategy seemed to indicate that participants did not consider supervision to be a sufficiently safe and containing space to bring all aspects of themselves and the work, they were not encouraged to reflect on what was evoked in them by their clients. This was problematic for several reasons: participants' construction of their countertransferential responses as an indication of incompetence remained unchallenged, their responses remained unexplored, at least in supervision, and for some, the supervisor's response to material they did disclose was experienced as shaming:

"I at some unconscious level edit material a bit ...certain countertransference responses um yeah especially the really negative ones yeah I'm much more likely to share with peers I think. So the feelings of being bored or frustrated much more likely to go to peers whereas the therapeutic triumphs (laughter) are much more likely to take to individual supervision to say well I tried this and it worked and this is what happened so yes so that's only really occurred to me now, that's a bit scary" Participant 4 [female, psychotherapist working in private practice].

"*I do a shared supervision but I actually don't want to share with the other person which makes it difficult…. where its coming from the origin I haven't really felt comfortable its very personal…I don't want to come here with shame"* Participant 7 [male, integrative therapist and trainee-counselling psychologist].

For participants in training the dual nature of supervision as a source of both support and assessment, led participants to attempt to manage the supervisory relationship as a way of ensuring a good supervisory report. Sharing countertransferential material was understood as potentially dangerous as participants feared that this could potentially show them in a bad light:

"I think she probably thought it was very successful and I certainly ticked all the boxes and got a really good report. You need the tick so and that's a tension that's not always acknowledged…I probably appeared like a good supervisee…it's quite easy really to manage the relationship such that it appeared neat and tidy, but actually the important stuff didn't get talked about it…it was a split so the judgmental supervisor got the good girl split and the work happened in a trusting environment" Participant 8 [female, counsellor and psychotherapist working within a university counselling service].

6.2 Locating unwanted parts of the self in others

Participants who remained uncontained appeared to attribute their difficult feelings to their clients; many described feeling judgemental and critical towards their clients:

"She would say it quite seriously and I would be sitting there going and my eyes would be like going, as I could always feel it and thinking, feeling glad that she looked out the window, it would be nice that she would be looking away from me as there was a sense of my eyes popping out of my head and that is a cold judgment and I would be like ok, draw that back in a little bit…. So there's all those things that I felt that I was giving away but she's almost expecting some kind of response to be a bit negative and equally she kind of smiles at the end of it as she knows that it makes me feel awkward" Participant 2 [female, IAPT Psychological Therapist and Trainee Counselling Psychologist working in the NHS].

"I felt she was really trying to run the show in a big way. I didn't particularly like that in her…I think the thing I missed was those are all traits in me, that I don't like, (laugher)….I remember thinking gosh you're really annoying, but what's that about and I couldn't see that it was about me, I keep looking at what it was about her. I think there would have been more successful, if I had owned that bit of me my relationship with her would have been different" Participant 9, [female, integrative psychotherapist working in private practice].

"I was so furious with him for doing that. I could feel it... fury with him, how dare you act out, if you're angry with me come and deal with that here. You don't kick the cat, and very combative, I was like right I'll take you on, which is just not the way you need to go when you're trying to be helpful…of course just blew the therapeutic relationship completely, because I think he was deeply ashamed but I got into sort of super-ego waggle finger mode" Participant 8 [female, counsellor and psychotherapist working within a university counselling service].

Judging other professionals appeared to be a protective strategy, which enabled participants to maintain a sense of competence through projecting their feelings of incompetence on to others:

"you know it's like, putting so much jam on a piece of toast it's sickening, um that you know it's almost as if they see bogey men where there aren't any. Um you know transference where there isn't any, with the way some people practice who are very in to making assumptions about people and they make interpretations and pronouncements, um and I do find that irritating, course that's another things that's swayed me in the directions I've gone, if I find that irritating what might a client feel" Participant 6, [female CBT therapist & trainee counseling psychologist working in an NHS IAPT service].

Acting out Countertransference Response

Where there was a failure of containment and the opportunity to reflect on countertransferential material, participants found themselves repeatedly acting out their countertransference response, by either *becoming under available* or *becoming over available,* as they unwittingly engaged in re-creating the client's relationship dynamics. While enactments are an important part of relational work, when participants were unable to reflect on what was playing out in the client-therapist dyad, they became problematic. In the absence of countertransference awareness, participants were unable to utilise their responses either to inform the work or to further their self-development

7.1 Becoming under Available

Analysis of the actions in the data indicated that participants appeared to become under available to their clients in a variety of ways. Some participants described how they became engaged in power struggles with their clients because they were feeling, both challenged and undermined, by the client's responses towards them. The client's behaviour, therefore, led to some participants feeling threatened by the client's need for agency, indicating that there was a conflict between the needs of the client and the needs of the participant.

Participants seemed unable to consider what might be occurring within the client-therapist dyad and instead became focused on removing their discomfort by trying to regain a sense of control:

"she was really quite hard to manage in the session...my sense of the client was that she was a bit narcissistic and she wanted to know before I was trying to tell her, or summarise, even though she knew it she didn't like the fact that I could do it in bite size chunks and I think that threatened her" Participant 2 [female, IAPT Psychological Therapist and Trainee Counselling Psychologist working in the NHS]:

"…. He said to me when does treatment start after about 3 sessions I said well you know it could have started a long time ago if you'd quit telling me about Dr whatever as lovely as I'm sure he is um I don't know that we need a 3rd person in the room…after I read him the riot act, about could we leave Dr whoever outside please he was a lot less so um but he was condescending and dismissive towards me" Participant 6 [female, CBT therapist and trainee counselling psychologist working in an NHS IAPT service].

Participants 15 described how he fantasised about the client not turning up, rather than reflecting on relational dynamics, which led to him becoming less present and congruent within the relationship:

"I can remember feeling really quite irritated, and kind of angry about, you know this person was wanting the help but wasn't wanting to do the work…I was really really irritated during the session also kind of afterwards and I suppose thinking about maybe not looking forward to seeing this person…thinking about if they didn't turn up then I wouldn't have to feel so irritable" [male, CBT psychological therapist working within NHS IAPT service].

Some participants described how they increasingly withdrew emotionally from the work to move away from the affect stimulated within them. This led to participants becoming emotionally unavailable to both the client and themselves, and to being less engaged in the relationship. Participants described how they attempted to supress their emotions, which shifted their focus away from the client, as well as preventing them from reflecting on why these feelings had arisen.

"...a person who was constantly challenging even if I nodded or hummed. .literally couldn't say anything right and then I was mute, became mute, my supervisor didn't think that was a good place to be, I just then didn't want to say anything, because whatever I said I got jumped on" [female psychological therapist & integrative counsellor working within an NHS setting and private practice]

"I think sometimes if the CT response is a feeling of um panic it can lead me as a therapist to shut down and calibrate I'm going to sit like a mountain and sits this one out and I then close off to other emotional responses so I sort of shut down like a trip switch goes off" Participant 4, [female psychotherapist working in private practice].

Another avoidant strategy was to bypass feelings by becoming directive and task orientated; in this way, participants became overly focused on the task rather than the relationship.

Participant 2 described how she attempted to fill the sessions with a client rather than considering why she felt the need to do this; in this sense, she acted out her countertransferential sense that the session would be empty if she did not prepare excessively for it. Rather than exploring what the feeling of emptiness, or her own need to do everything for the client, might indicate:

"He was someone I felt that every session I would plan and prepare, I wouldn't…really need to plan as I know it but with him I did…So I kind of had to have all this stuff ready and we go through it really quickly and I would wonder how we would fill up the rest of the session" [female IAPT Psychological Therapist and Trainee Counselling Psychologist working in the NHS]

Participants who lacked containment understandably struggled to contain and tolerate the client's experiences and affect; this was particularly difficult when their own material was triggered. Participant 6, shares very candidly her experience of working with a male client who had violently assaulted his partner:

"*I really didn't like this guy its true and when he dropped out of therapy and he said it was my fault...um I was really pleased he went, being really honest… Of course the thing is I realised I disliked him, and that he reminded me of various things in my past you know younger life and um including an ex-husband. And um you know if he had not dropped out of therapy then this would have been a real problem*" [female, CBT therapist and trainee counseling psychologist working in an NHS IAPT service]

Service demands and outside pressures also led to participants becoming less emotionally available to their clients as these increasingly overwhelmed them. This led further withdrawal from the work as a way of managing overwhelm:

"I just did not pick up the negative transference quickly enough and we got into a terrible muddle and I just felt dreadful because she ended in a bad place we couldn't repair it she'd been damaged and of course you don't go into this place to make people worse you know that's and I did my best to retrieve it but just couldn't, I was distracted, a waiting list, and it tends at certain times of year its get them in get them out, and just took my eye off the ball" Participant 8 [female, counsellor and psychotherapist working within a university counseling service].

7.2 Becoming over available

Conversely, some participants acted out their countertransferential responses by becoming over available to their clients, which made it difficult for them to retain a degree of separateness in the relationship; this enmeshment seemed to give the illusion of a strong alliance, as the enactment remained outside of their awareness. Participant 7 reflects on how identifying with a client's experience resulted in him stepping outside his usual role:

"So, I'm sitting in a meeting and someone said we've never had someone from GP surgery come before, like the counsellor, and I just thought hmm, this means something…kind of thought yeah what am I doing here laugher, actually why am I here…maybe I was stepping in that way, perhaps even repairing something of my own life…Completely out of my awareness" [male, Integrative therapist and trainee counselling psychologist]:

Participant 9, reflects on her need to please her clients, meant working harder in the relationship, which was driven by fear that her clients would stop coming to therapy unless she responded to them in a specific way:

"I was unaware of how I was responding to them and trying to please them, as a trainee and there a lovely and they come along and they know I'm a trainee and so they're given their time and all that kind of thing" [female, integrative psychotherapist working in private practice].

One participant described how she became so caught up in helping the client move forward she lost sight of what was taking place in the relationship. Collusion was hidden behind the illusion of a good alliance, as the interpersonal dynamics at play in the relationship remained unexplored:

"*It very easy for me to get drawn into that I'm sort of special sort of a thing because I knew how many therapists this person had seen before and how many of them had rejected her...I was losing myself in her, in her situation… I was letting myself feel angry with him and that was not helping her. It was not very long after that that we terminated therapy...it was very emotional and I didn't keep it at sufficient distance"* Participant 1 [female, psychologist working in private practice].

It is important to stress that the two pathways are not binary or fixed: participants appeared to move between the two pathways depending on their experience of containment. When participants, for example, completed their training this often led to a change in both supervisor and organisational context. For some this led to a move onto the reflective pathway, as they began to experience a new supervisory relationship, which attended to countertransference and offered a containing space, thus enabling awareness to develop. For others, they moved onto the more defensive pathway, as the organisational and supervisory context no longer privileged reflective practice or attention to the relational dynamics. Without a space to reflect, participants were unable to develop their awareness further to the benefit of themselves or the client.

Discussion

Summary of findings

The purpose of this study was to explore and delineate the processes involved in the development of countertransference awareness, and to consider if this developmental process was felt to influence the therapeutic relationship in any way. The findings outlined above suggest that this development is facilitated by several containing factors: a theoretical framework, which enables and encourages reflection on countertransference, training and organisational contexts, which provide the opportunity for reflective practice, personal therapy and the motivation and self-insight of the therapist/participant themselves. The outcome of countertransference development is twofold: increased self-awareness on the part of the therapist, which enables the therapist/participant to differentiate between their own and the client's dynamics. Secondly, the development of a two-person psychology, in which the therapist constructs themselves as *tolerating vulnerability* and *being with but staying separate*. Both outcomes enable the therapist/participant to tolerate the stimulation of powerful affect in the therapeutic situation, while remaining present and available within the therapeutic relationship.

In contrast, when these containing functions were absent, participants struggled to make sense of their countertransferential responses, which resulted in these being acted out in the therapeutic relationship. These struggles seemed to have a negative impact on the therapeutic alliance, with some relationships becoming stuck or ending prematurely. Without the containing framework outlined above, participants constructed their feelings and responses as incompetence, resulting in the adoption of defensive strategies.

Experiencing a Threat to Self

Experiencing a threat to self-captures participant's accounts of their experiences when they started their clinical training. These are broadly defined as becoming *overwhelmed by countertransference responses*, *struggling to understand theory and practice*, and *judging self and fearing judgment*.

The existing research and theoretical literature indicate feeling overwhelmed as a trainee therapist is not unique to the participants in this study. According to Marroda (2012) trainees often experience clinical encounters as disturbing, as despite best intentions, they struggle with their own emotional experience. Furthermore, because trainees fail to understand being impacted by the client is a normal and expected aspect of the work (Burwell-Pender & Halinski, 2008; Truell, 2001), they tend to feel ineffective and inadequate, particularly when they have constructed an, 'idealised' view of the professional self, which is 'omniscient', caring and empathic and always effective (Kumary & Baker, 2008; Skovholt & Ronnestead, 2003; Stefano et al, 2007; Truell, 2010). According to Barnett (2007) when confronted with limitations and vulnerabilities, trainees fail to meet their idealised professional self, resulting in feelings of failure, incompetence and sense of shame about not being good enough. This according to Glickauf-Hughes and Mehlman (1995) can evoke narcissistic vulnerability in trainees, as when confronted with vulnerability and limitations, trainees doubt their suitability for the profession, doubts, which they fear, will be shared by teachers and supervisors. They suggest this fear results in the development of a false professional self, where vulnerability is split off and hidden to preserve an impression of competence. This literature is consistent with the current research literature, which has found trainees report feeling ill equipped to respond to another's distress, and that they frequently feel distracted and overwhelmed by internal affective states (Cartwright et al, 2014; Cohen & Hatcher, 2008; Hill, Sullivan Knox & Schlosser, 2007; Nutt-Williams, Polster, Grizzard, Rockenbaugh & Judge ,2003; Nutt-Williams & Hill, 1996; Theriault, Gazzola & Richardson, 2009; Truell, 2001).

These studies found trainees constructed their struggles as an indication of incompetence, leaving them doubting their therapeutic abilities. This is consistent with the present study's findings, where participant's vulnerabilities evoked feelings of overwhelm and incompetence. Interestingly, learning psychodynamic theory did not reduce participant's fears, it only added to them, evoking further feelings of overwhelm and incompetence, a finding which supports the literature on the experience of learning to psychodynamic therapy (Fitzpatrick, Kovalak & Weaver, 2010; Fontaine & Hammond, 1994). Fitzpatrick, Kovalak and Weaver (2010) suggest learning psychodynamic theory can leave trainees feeling overwhelmed, scared, disconnected, bombarded and daunted, because the theory is initially so abstract, trainees can struggle to use it to the benefit of practice. Furthermore, these researchers suggest that much of psychotherapy processes, such as tolerating ambiguity and uncertainty, cannot be learned intellectually. This according to Fontaine and Hammond (1994) results in a dichotomy, needing theory to understand experience and vice versa, a view supported by the findings of the present study.

It is interesting to note that not all participants in the present study reported feelings of overwhelm or reflected on their internal affective states when interviewed. While training experiences will clearly vary, it could be that attention to one's internal world doesn't warrant the same attention for some therapeutic approaches. CBT, for example, has paid less attention to the internal experience of the therapist (Gelso & Hayes, 2007). This may suggest that if attending to internal experiences is constructed as unimportant these experiences are more likely to remain outside therapists' awareness.

The Reflective Pathway

As participants progressed through their training they began to follow one of two pathways, a reflective pathway or a defensive pathway. The findings of the present study suggest the experience of containment plays a central role of in the development of reflective capabilities, necessary to develop countertransference awareness.

Within the counselling and psychotherapy research and theoretical literature, while there is an emphasis on the importance of reflective practice for the development of self-awareness, there has been less attention given to the conditions, which facilitate this process (Donati & Watts, 2005; Pieterse, Lee, Ritmeester & Collins, 2013; Richards, Campenni & Muse-Burke, 2010). Furthermore, according to educational psychologists Bemark and Epp (2001), little attention has been given to how novice counsellors are taught to develop awareness of countertransference, let alone how they then apply this to practice. The findings of the present study, therefore, go some way towards addressing this gap as they indicate that to develop countertransference awareness in the face of quite considerable threats to self, trainee therapists first need to feel contained.

Experiencing containment

Participants experienced containment in a number of contexts, and these experiences were instrumental in the move away from defending against internal and external threats and developing countertransference awareness through the process of reflection. The psychodynamic literature suggests that a major barrier to reflective practice can be the adoption of defensive strategies to deal with the emotionally charged nature of the therapeutic encounter (Pietroni, 1995). Containment therefore offers a conceptual framework for understanding how participants in the present study faced, understood and effectively thought about their countertransference, rather than defensively discharging it. According to Bion (1961) for reflective practice to be possible, ‘containers’ need to be provided, which offer the appropriate physical, mental and emotional space required to engage in reflection. This indicates that the environment plays a central role in the development of reflective practice. Winnicott (1956, 1957, 1960) posited that while the environment did not make the child, it was still a crucial enabler.

The findings of the present study indicate that the environment plays an important role in the development of the therapist, and that the most containing environment, is one where there is a symmetry between the training programme, the place of work or placement, the supervisor and the therapist, all of which create a culture where reflection is not only valued, but considered a core part of the work. Therefore, while supervision was identified as the most salient place where participants initially developed their countertransference awareness, it is important to note that this was only made possible because of the culture in which the supervision was situated.

It is widely agreed within the counselling and psychotherapy literature that supervision is often where therapists first begin to develop their countertransference awareness (Pakdaman, Shafranske & Falender, 2015), a suggestion that is supported by the findings of the present study. What is understood to a lesser degree is what enables a therapist to begin to share the more difficult aspects of the work, given the amount of anxiety and fear of incompetence that exists, and the need for respect and approval from the supervisor (Dodge, 1982). Pope, Greene and Sonne (2006) have suggested that disclosure is more likely when there is a sense of safety and basic trust in the integrity of the supervisor, because exploring topics, which may feel ‘taboo’, or threatening in some way involves taking a risk on the part of the supervisee. Safety therefore comes from the knowledge that what is shared will not be a threat to the personal and professional self (Pope, Greene & Sonne, 2006).

The psychodynamic literature is helpful for theorising this sense of safety further. The containing supervisor it is suggested is analogues to Winnicott’s (1956) ‘good enough mother’, offering a facilitating environment to ‘hold’ and empathise with the trainee’s clinical experiences, while they carry on engaging in the work.

According to Winnicott much like the infant, the beginning therapist lacks the required ego strength to tolerate impingements from the environment and the supervisor, much like the mother, through the provision of a holding environment, provides a ‘container’, where the ‘unbearable’ experience, can be made more tolerable. Drawing on the work of Bion (1961), psychoanalyst Stewart (2004) suggests that the supervisor’s mind provides a containing function for the therapist/supervisee, which helps to process and conceptualise the material that they are bringing. This, Stewart suggests, helps to transform the material into a meaningful experience, offering a new perspective on the material and developing the trainee’s awareness. It is through this containing process, according to Mollon (1986), that the narcissistic injuries inherent in learning, can begin to diminish.

According to Molad (2001) it is through the understanding gaze and gentle coaxing to ‘open up’ by the supervisor, which enables the therapist/supervisee, in a state of heightened vulnerability, to begin to disclose, breaking down the wall of shame. Through the containing experience, counselling psychologist Palmqvist (2016) suggests, the trainee can dare to develop a professional identity which is governed by their true self, as trainees discover it is possible to have vulnerabilities and limitations and also be a ‘good therapist’. The present study can add some empirical support to this literature; the supervisory process was key for participants in making sense of previously threatening material, when invited and encouraged to disclose by the supervisor. Given that participants in the present study seem to move away from the need to present as a ‘competent’ professional, perhaps indicates containing contexts offer an environment where participants could begin to develop a professional self, more aligned with the ‘true’ self. This seems to add to the literature in an important way, as it suggests what makes the application of a relational theoretical understanding of countertransference possible, is the experience of a containing context.

Countertransference awareness was also identified by participant's as developing in personal therapy, as this offered a space for the exploration of material evoked by the work, which often seemed to lead participants to reintegrate previously disowned parts of the self. There is some support in the wider literature on the benefits of personal therapy in developing self-awareness. According to counselling psychologist Kumari (2011), personal therapy can help therapists gain more insight into interpersonal dynamics by increasing self-awareness in the therapeutic relationship. Kumari has also suggested that adequate self-awareness is essential to ensure that the therapist does not become completely overwhelmed by seeing clients who are often extremely distressed. Personal therapy can therefore aid the therapist in separating out his or her own issues from those of the clients and in doing so, reduces the possibility of countertransference enactments (Kumari, 2011). There has been some debate in the literature on whether personal therapy should be mandatory for therapists in training, as according to some authors there has been no empirical evidence to show that it has benefited client outcomes (Atkinson, 2006; Clarke, 1986). The findings of the present study add to this debate; it was through the engagement in reflective work in personal therapy that participants developed their insight into their own dynamics. Given that the findings suggest a lack of countertransference awareness can result in countertransference enactments in the therapeutic relationship, these findings add considerable support to the argument that developing awareness of personal dynamics and blind spots are critical to the work of therapy and the ongoing development of the therapist.

Becoming integrated

Becoming integrated captures how through the process of experiencing containment, participants developed their ego strength, resulting in a more integrated self, and by integrating theory and experience, it increased their ability to tolerate ambiguity in the therapeutic process.

While theory is understood to offer a sense of order to the experience of therapy, thus offering containment to the therapist (Bion, 1970, Casement, 1985), Kottler (1991) suggests this is only possible if the theoretical concepts make sense to the therapist. This assertion is also supported by Orlinsky, Botermans and Ronnestad (2001) who assert that integration is dependent on whether an individual accepts the theory as offering a meaningful interpretation of their experience, or rejects it. The findings of the present study support this claim; those participants who integrated a relational understanding of countertransference were those who had experienced this construction as helpful in making sense of their experiences in a meaningful way, while also supporting their on-going learning and development. This perhaps helps to explain why participants began to develop their capacity to tolerate internal and external stressors, as they did not seem to hold them same meaning, which also helped participants to integrate previously disowned parts of self.

The psychodynamic literature suggests an integrated self is made possible through the development of a strong ego (Bjorklund, 2000; Qarachanaq, Pormouzeh & Loo, 2015; Mahapatra, Sahoo, Mishra & Kumar, 2010; Shepherd & Edelman, 2009). When an individual has developed a strong ego, it is suggested this increases an individual's capacity to tolerate internal and external stressors and threats. A significant part of this process, Aponte and Kissil (2014) family therapists, argue, is self-acceptance as this enables the therapist to move away from trying to hide and deny the more shameful aspects of self, to accept their flaws and limitations, thus relinquishing the illusion of perfection. This according to Aponte and Kissil enables a therapist to begin to identify and differentiate their own material from that of their clients, which they suggest is critical in helping therapists to stop acting from their own motivations and needs. For participants in the present study, an important part of this process was being able to let go of their constructions of who they thought they needed to be.

Psychoanalyst Wheeler (2002) argues when the emphasis moves away from the idea of the therapist as the 'healed one' and the client as the 'wounded one', therapists are more likely to develop their awareness and insight into their own wounds and vulnerabilities, making these less likely to arise in the work (Wheeler, 2002). This suggestion is supported by Gelso and Hayes (2007), who posit that when a therapist can develop an integrated self, they are more able to identify the borders between self and client, which helps the therapist to tolerate, identify and own their own responses, rather than attribute them to the client (Hayes et al, 1991). Becoming integrated was a significant finding in the present study, adding empirical support to this literature, emphasising the significance of self-insight in participant's capacity to differentiate between, their own material and the clients, a crucial part of developing a two-person approach to the work. This also perhaps helps to explain why temporal states of self-awareness can be experienced as overwhelming, thus adding to the existing literature (Fauth & Williams, 2005; Nutt-Williams et al, 2003; Nutt-Williams, Hurley, O'Brien & Degregorio 2003; Williams, 2003), as it was partly through the development of self-insight that participant's internal states ceased to overwhelm.

Developing a two-person approach

The internalising of containing experiences and the development of an integrated self, as discussed above, appeared to enable participants to tolerate their own vulnerability, which seemed critical to remaining present in the therapeutic relationship. This also enabled participants to develop more of an interest in a two-person approach to work, one where they could reflect on their countertransference. Participants described being able to remain present and in contact with the client's experience, while being able to observe and reflect on what was occurring within the relationship. This supports the literature, which suggests therapists who recognise the borders and difference between their own and client's experience, are more able to remain emotionally present, while not becoming overwhelmed by the feelings of the client (Dieplod, 2015; Geller 2013; Loewenthal & Samuels, 2014; Moltu, Binder, Nielsen, 2010).

According to Loewenthal and Samuels (2014), this requires a therapeutic stance where therapists construct themselves as co-participants in the therapeutic endeavour, who are open to being affected and moved by the client, while also being open to their own experience. Stark (2000) describes this as 'working at the intimate edge of authentic engagement', which Stark suggests can be intensely demanding of the therapist (p. xx). According to Stark a relational therapist attends closely to what the clients delivers of him or herself into the therapy relationship, while also paying attention to their response or 'reactivity' to what the client delivers. To be an effective container, Stark suggests a therapist must first tolerate what the client delivers into the relationship, as well as having the 'wisdom to recognise and integrity to acknowledge, their participation in the enactment' (p. xxi). Geller and Greenberg (2002, 2012) therefore suggest that being able to tolerate vulnerability is a crucial starting place in the clinical encounter, as it is through the awareness of bodily sensations and emotions that the therapist can begin to connect more deeply with the client. Furthermore, when the therapist can hold and contain the client's experience by remaining open, present and receptive, it is suggested it can offer the client a reparative and healing experience (Crenshaw & Noziska, 2014; Geller & Greenberg, 2002; Geller, 2013).

Being able to reflect on the experience in the unfolding relationship, according Payne (2001) allows the therapist to understand and empathise with the client not from a place of prior knowledge or theory, but from direct experience in the relationship. The present study can add to the literature here, as the capacity to remain engaged without becoming overwhelmed was made possible becomes of the level of integration and self-insight that participants had developed, as this enabled them to differentiate between their own and the client's experience. A key part of participants developing a two-person approach to the work, was therefore tolerating their feelings in the therapeutic relationship, making them more accessible for reflection.

The Defensive Pathway

In contrast to those on the reflective pathway, participants who encountered countertransferential threats to the self, without adequate containment, were unable to reflect on the cause of their distress, and so adopted defensive strategies to manage their anxiety. These reduced opportunities for personal growth and development; resulting in participants unwittingly acting out in the therapeutic relationship.

Experiencing a lack of containment

When participants did not feel adequately contained, many adopted defensive strategies which, in the absence of suitable containment, they failed to revise. According to clinical psychologist O' Connor (2006), when there is an absence of a container, the uncontained individual has no choice but to defend against what is experienced as harmful. Furthermore, O'Connor suggests that if the individual has not internalised the capacity to contain, they will be unable to manage anxiety when and if, it arises. Within the literature, it is possible to identify two barriers to reflective practice, internal barriers to considering the emotionally charged context of work, and external barriers arising from the wider culture of the organisation (Ruch, 2007). Part of the problem for participants in the present study, was they lacked a framework in which to conceptualise their experiences; which adds support to the literature, which identified conceptualising countertransference as a key component in managing countertransference (Robbins & Jolkovski, 1987; Van-Wagoner et al, 1991). When the prevailing culture doesn't attend to interpersonal dynamics, including countertransference issues, Mollon (1986) suggests that therapists will be 'handicapped by their culture'. According to Sumerel (1994) in certain contexts, some supervisors do not consider supervision the place to attend to therapist's emotions or the interpersonal dynamics in the client-therapist relationship.

An assertion supported by Bridges (1998) who suggests that some contexts consider attention to the therapist to be necessary only when there has been an ethical or boundary issue. Both Sumerel and Bridges suggest that this risk's neglecting crucial areas of psychotherapy process, such as, mutual enactments, in both the client and the supervisory relationship. The findings of the present study highlight that without a framework in place to explore interpersonal dynamics it is inherently more difficult, for supervisor and therapist to reflect upon countertransference reactions. Part of the problem for many participants seemed to be the organisational contexts in which supervision took place, which had a therapeutic culture, which focused on the clients presenting problem(s) rather than the quality of the therapeutic relationship.

Stewart (2004) suggests that organisational contexts that work with large caseloads, offering short and rapid interventions can result in superficial non-reflective supervision. It has been suggested that these organisational influences upon the client-therapist relationship have been under addressed in supervision (Tobin, 2003). Organisational psychologists Cilliers and Harry (2012) suggest that any system, person, group or organisation unconsciously needs something or someone to contain the anxiety on its behalf. According to Brady, Healy, Norcross and Guy (1994), the ideal workplace environment for therapists should be a safe haven, a place that both holds and contains the therapist, who is engaged in emotionally challenging work. They note however, that the workplace environment can become another source of stress. The organisational context has received a great deal of attention within the healthcare literature, which suggests that the lack of a containing structure, can leave healthcare workers experiencing a great deal of distress (Fotaki & Hyde, 2015; Hinshelwood & Skogstad, 2002; Ruch, 2007). Menzies-Lyth's (1960) seminal work on nursing outlines the organisational defences adopted to avoid psychological involvement with patients. Participants in the present study were similarly defended, and therefore unable to reflect on and learn from their work.

Counselling psychologist Rizq (2011) has drawn parallels between the Menzies-Lyth study and the Improving Access to Psychological Therapy (IAPT) services. According to Risq (2011), the current IAPT system has become task focused, which limits therapist's emotional engagement with their clients by encouraging working practices, which minimise client contact, such as protocols and large caseloads. Furthermore, Risq suggests the current IAPT programme is explicitly identified and tasked with, what might be termed, 'well-being work' and is underpinned by organisational structures, that defend against and minimise, notions of vulnerability and dependence. This is consistent with the findings of the present study, where participants constructed the IAPT service, in which some participants worked, as a barrier to engaging in any form of reflective practice. Participants described how following protocols were favoured over attendance to the therapeutic relationship, which was considered akin to 'opening a can of worms'.

This perhaps indicates that the adoption of protocols can be used as a defence against emotional engagement with the client. According to Stewart (2004) when task focused therapy lends itself to '*doing to'*, it can be used as a defence against *being with* a client, if this is experienced as overwhelming or anxiety provoking. This then promotes a culture or a collective defense; rather than the engagement in the realities of the work*, doing to* just becomes part of the organisational culture around 'how things are done' (Long 2006). Price and Paley (2007) suggest that when the therapeutic setting is inadequate to contain the anxieties inherent in the work, this will directly affect the therapist's capacity to contain the client, a suggestion supported by the findings of the present study. These findings therefore make an important contribution to the literature, by outlining how the absence of a containing context has a detrimental impact on the client, the relationship and the ongoing development of the therapist.

Adopting Defensive Strategies

Many participants described constructing their countertransference responses as an indication of incompetence, which then appeared to result in the adoption of defensive strategies. 'Defences are understood as strategies that are employed either knowingly or unknowingly, to avoid facing aspects of self, which feel threatening' (Jacobs, 2010, p104). As such, defences are used to protect the self from the experience of powerful feelings, thoughts, actions or events, which threaten to overwhelm (Jacobs, 2010). As a result, the use of defence mechanisms enables a temporary degree of emotional safety to be achieved (Cilliers & Harry, 2012). In the present study, one form of defence adopted by a few participants appeared to be the formation of a false professional self. A false self, it is suggested can develop as a way of hiding and concealing the true self or aspects of self, which are threatening in some way (Barnett, 2007; Molad, 2001). According to Winnicott (1960), the role of the false self is to conceal and protect the true self from environmental impingements. Winnicott believed it was a defensive organisation formed due to inadequate parenting, where the infant adapted its needs to meet the needs of the mother, on whom he was dependent. Winnicott believed reacting to impingements would then become the pattern of the infant's life, with the needs of the true self-split off. This he suggested would prevent the development of an integrated self, as parts of self would remain hidden.

The present study can add some empirical support here, as participants described having two selves, the idealised professional 'competent self' and the 'wounded' and inadequate self, the former considered the more likely version of self to be accepted by the profession. Given that the literature suggests that a need to conceal parts of self can be to avoid potentially shaming experiences (Ladany, Hill, Corbett & Nutt, 1996; Mehr, Ladany & Caskie, 2010; Molad, 2001; Skovholt & Ronnestad, 2003; Southern, 2007; Yourman, 2003), perhaps indicates that some participants carried a great of shame about their true selves.

According to Dodge (1982) when a therapist self-worth is reliant on external approval, doubts on performance and competence can evoke result in withholding material, inhibiting the therapists learning process. A view shared by Molad (2001) who suggests, a consequence of splitting the self, is growth can only occur within the certain parameters. While this diminishes opportunities for growth and learning, psychoanalyst Yourman and Faber (1996) suggest it also compromises what can be offered to the client. Given that participants were not being helped to think about the work by their supervisors, seems to suggest that it wasn't just the participants who were avoiding the material. This supports the assertion that unless supervisors have the skills and confidence to attend to intrapersonal issues and countertransference material, then this material will remain unexplored as trainees don't have the ego strength or awareness to disclose potentially threatening and shaming material, without the supervisor's invitation to disclose (Bridges, 1998).

As well as editing, some participants defended their sense of self by projecting their vulnerabilities and struggles onto their clients and fellow professionals. According to Hahn (2001) shame arising from aspects of self, which have been devalued in some way, can be projected onto another as a way of protecting the self from experiencing the shame. Hahn suggests that these disowned aspects are then attacked criticised and further devalued, as a way diverting the attention away from the individual's own sense of shame. The fact that participants in the present study felt the need to edit their material, hide their struggles in the work, and project these onto clients and other professionals, seems to offer some empirical support for this assertion. It is also interesting to note that in the interview some participants focused on their clients and other professionals rather than reflect on themselves, which perhaps is an indication that their false professional self also manifested in the interview.

Acting out Countertransference Response

The findings indicate that when countertransference remained outside of awareness and unrecognised, participants acted out in the therapeutic relationship, which seemed to undermine the work with the client. Within the psychodynamic literature, Leitner (1995) identified two types of countertransference enactments, too close, enmeshment and too far estrangement, which could arise if a therapist failed to achieve an optimal distance in the relationship, which he suggests is close enough to experience the client's feelings but far enough to be able to reflect on the source of the feelings. This is consistent with the findings of the present study as participants described two main forms of acting out in the therapeutic relationship: becoming either *under* or *over available*.

Becoming under available in the therapeutic relationship, it has been suggested is a defence against feeling uncomfortable or painful internal feelings (Gelso & Hayes, 2007; Hansen, 2007). According to Sharking and Gelso (1993), when the therapist struggles to deal with the client's affects, this can be an indication of the therapist's own issues being evoked in the room. According to McHenry (1994) when therapists lack awareness of their role in the enactment, they risk responding to the client in counter-therapeutic ways, as they become focused on removing their own discomfort. McHenry suggests this will impact on the client, who is unlikely to feel understood or contained. McClure and Hodge (1987) suggest this can result in therapist becoming distant and less present in the relationship, resulting in less empathy and understanding towards the client. The literature suggests this can lead to a failure in containment for the client, as it can potentially validate or intensify their existing beliefs regarding relationships, while reinforcing their view that their problems cannot be solved or they cannot be helped (Sherman & Anderson, 1987; Waska, 2010). The findings of the present study, add some support here as they highlight when the therapist cannot reflect on their countertransference, this impacts negatively on the client and therapeutic relationship.

This seems to suggest without a containing framework in place, which attends to the therapist countertransference, it will inevitably lead to therapists unwittingly acting out in the therapeutic relationship, as they will lack the necessary awareness to attend to and manage their countertransference responses.

Although reported to a lesser degree, for some participants they became over involved in the relationship, as they struggled to retain a degree of separateness in the relationship. This excessive closeness in the therapeutic relationship has been described as an enmeshment, in which the therapist may struggle to separate the client's struggles from his or her own (Leitner, 1995). Gelso and Hayes (2007) highlight that when a therapist becomes enmeshed with the client, they have failed to recognise the borders between themselves and the client, which can only come when a therapist had developed a good level of self-insight into their own dynamics, needs and conflicts. Gelso and Hayes (2007) describe the therapeutic relationship as a dance; 'close enough to keep contact but not so close it interferes with the movement' (p.99). They suggest that while enmeshment might feel good to both the client and the therapist, effective therapy requires an appropriate distance. This perhaps helps to explain why participants in the present study seemed to confuse being over involved with a good therapeutic alliance. Furthermore, being over involved was constructed as more positive and less harmful than being under involved, possibly due to the more positive feelings over involvement evokes. Without the opportunity to reflect on this dynamic, it was as if enmeshment was easier to overlook.

It is interesting to note that a few participants became aware of their role in the enactment through the process of the interview, suggesting that the interview offered a place where reflection could take place, which had not been previously available to participants. This seems to add support to the role reflection plays in developing countertransference awareness, and that the interview thus afforded participants a containing and reflective space, which previously had been unavailable, maybe indicating something of their motivation to participate in the first place.

Implications of the findings

The findings of the present study have offered a grounded theory on the process of the development of countertransference awareness, which has offered some important empirical support for both the utility of the construct in practice and that for awareness to develop, several processes need to be in place. The grounded theory outlined above, indicates the importance of containment in developing reflective practice, countertransference awareness and personal development in trainee therapists. The findings also outline the dangers involved when containment is lacking, which can jeopardise both the trainee's development, their ability to reflect on their work and their therapeutic relationship. As such these findings have clear implications for practice for trainee and qualified counselling psychologists and for those professionals involved with their training and their professional development.

Counselling Psychology Practitioners

To be able to develop countertransference awareness to the benefit of the therapeutic relationship, the findings indicate that trainee counselling psychologists need to develop a framework which will enable them to identify and understand their countertransference, as well as a commitment to engaging in reflective practice and personal development work. These findings are significant for the field of counselling psychology, which constructs reflective practice as part of its professional identity (Woolfe, 2012). The DCoP practice guidelines (2005) clearly outline counselling psychologists' responsibility to avoid doing harm to clients, through identifying, understanding and managing their own responses by engaging in reflective practice. The findings of the present study are helpful here, as they have identified some important processes, discussed above, which support practitioners to develop awareness and manage their countertransference to the benefit of the client-therapist relationship.

However, given that the findings of this study also indicate that engaging in reflective practice was not possible for many participants, this suggest that the responsibility for reflective practice involves more than the individual practitioner. Instead this responsibility needs to be shared by those involved in the training and on-going development and support of practitioners.

Counselling Psychology Training Programmes

The findings indicate unless trainees have a way of conceptualising their responses, they are left experiencing a great deal of anxiety regarding their own competence. Therefore, ensuring trainees are offered some teaching on countertransference, would seem of great importance to the development and containment of trainees while training. The findings also highlight the role personal development work can play in helping trainees to make sense of and manage their countertransferential material. However, while the BPS (2005) training guidelines place the responsibility onto the training provider to develop a clear rationale for any personal development work while training, no specific guidance is provided on this. According to Dryden & Thorne (1991), this has resulted in a lack of consistency in how personal development is addressed during training, with some programmes viewing development work as an 'add on', as it is presumed this work will be undertaken during personal therapy. The findings of the present study would seem to suggest that personal therapy alone is insufficient to develop counselling psychologists' awareness, and understanding of countertransference and therefore this also needs to take place at a training level. The findings of the study can therefore, offer both the Division of counselling psychology and those involved in counselling psychology training programmes, a comprehensive rationale for development work to occur more consistently and to a greater degree at a training level, given the benefits that can be gained for both, the trainee and the client.

Without this commitment in place, the findings indicate counselling psychology training programmes are at risk of failing to equip trainee counselling psychologists for the realities of training and the work, which the findings illustrate, creates a great deal of anxiety and overwhelm, which can be detrimental to both the development of the trainee and the development of a therapeutic relationship with the client.

The role of the supervisor

While the training context may serve as a place for trainees to begin to learn about countertransference theoretically, the findings seem to suggest that it is the clinical supervisor who may be in the best position to support the integration of theoretical and experiential learning. According to Ponton and Sauerheber (2014), supervisors are essential in the transition from theory to practice, with supervision key in helping trainees learn how to use themselves in the therapeutic relationship. Clearly for supervision to be effective in these circumstances, the supervisor needs to be able to facilitate a culture of trust, where the trainee can begin to develop their awareness. Helping therapists to manage their countertransference through supervision requires supervisors themselves to have a theoretical knowledge and understanding of the construct of countertransference or a comparative framework, which focuses on the therapist's feelings and responses as much as the clients. Without a framework, supervisor's risks facilitating a culture where the more challenging aspects of the work are not disclosed.

Personal therapy

While supervision is key in supporting therapist to develop their countertransference awareness, they also add considerable support to the need to engage with personal therapy as a mandatory training requirement for counselling psychology. Those participants in the current study who had developed self-insight through personal therapy felt more equipped to manage their countertransference when it arose in the work and were more able to understand their role in enactments as the self-reflective process facilitated by personal therapy helped develop awareness of their own dynamics and relational templates. Therapy is also important in developing an integrated and cohesive identity. Rogers (cited in Gelso & Hayes, 2007, p105), in an interview shortly before his death reflected on the importance of therapists recognising that they were 'imperfect and flawed'; Rogers argued that it is through the recognition of these flaws that the therapist can help another person (),

Organisational setting

The findings illustrate the struggles faced by counselling psychologists in environments where there is a failure of containment.
Given that counselling psychologists are increasingly working in mental health care systems which privilege targets and outcomes (Rizq, 2009) this clearly presents a challenge; how to maintain the values of counselling psychology, which privilege both reflective practice and attention to the therapeutic relationship, while working in services which have different priorities. The recent Health and Care Professions Council's 'practitioner psychologists' guidelines (2012) emphasise how the Counselling Psychologist, must be able to 'critically reflect on the use of self in the therapeutic process' and that the individual practitioner has a responsibility to cultivate and maintain an awareness of their self. Similarly, the BPS Counselling Psychology divisional guidelines (2005) claim that it is 'the responsibility of all Counselling Psychologists to encourage and develop the philosophy of Counselling Psychology'.

Yet what these guidelines do not address is how to manage the tension between the humanistic, relational values of counselling psychology, when working in contexts which adopt a rationalist, medical approach (Blair, 2010, Chwalisz, 2003). According to Blair (2010) contexts, which ascribe to a medical model of therapy, construct too narrow a view of the therapeutic process, which isn't amenable to what counselling psychology holds as important, i.e. relational factors and inter-subjectivity. The findings, therefore, suggest that this challenge needs to be addressed at a divisional level to prepare trainees for working in, settings which do not share the same philosophical values, or commitment to reflective practice

Psychodynamic Theory

It has been argued that psychodynamic theory is redundant in current mental health services due to its lack of an 'evidence base'. Some CBT theorists have argued that it is more akin to a 'pseudoscience' (Salkovskis & Wolpert, 2012), an attitude that has led to the benefits of psychodynamic theory being disregarded (Fonagy & Lemma, 2012). The processes identified in the current study add considerable support to the relevance and utility to current practice of both psychodynamic theory and the construct of countertransference, as the findings suggest it is a useful theory for understanding interpersonal dynamics in the therapeutic relationship and the dangers of unmanaged countertransference.

Recommendations for practice

More attention needs to be given by training programmes, placement providers, service providers and supervisors to the experience of trainees and the importance of containment. Findings from the current study indicate the need for a coherent theoretical framework, one that normalises countertransference responses and actively models self-disclosure. This would support trainees to learn how to use supervision honestly and openly so they can reflect on all aspects of the work and the training experience and would help them to manage their affective responses to their clients. Training programmes need to contextualise developmental work so that therapists are aware that the process of developing self-knowledge and self-insight is a critical component in identifying and managing countertransference. This seems particularly important considering that trainees frequently struggle with doubts and fears around incompetence, which, when not contained, can result in defensive practice and shame. Reflection on the difficulties and vulnerabilities arising in the work need to be prioritised in coursework assignments and supervisory reports.

By exploring and delineating the processes by which countertransference awareness develops this thesis has identified that the central role of containment in this development. The role of containment would, therefore, seem to deserve further empirical attention.

Recommendations for future research

It would be fruitful to build on the findings of the present study to investigate how therapist countertransference behaviours impact on the therapeutic relationship from the clients' perspective. Given that enmeshment with the client was constructed more positively and perhaps considered of less concern suggests that this would benefit from further attention. As training was identified as a key component in awareness development, it would be beneficial to research how countertransference is taught in different schools of therapy and how this relates to awareness and management of countertransference. It would also be useful to explore how different therapists engage in developmental work and reflection and whether there are difficulties and/or limitations in practice of assimilating the construct of countertransference into different theoretical perspectives.

Dissemination of the findings

Being able to disseminate findings is an essential part of the research process to inform and benefit practice.

Findings from this study will be disseminated as follows:

- Publication in the form of journal articles,
- Presenting the findings at counselling psychology, psychotherapy & counselling conferences,
- Offering webinars or online teaching, for example, through organisations such as CONFER,
- Incorporating the findings into my own teaching practice to develop counselling psychology and psychotherapy trainee's awareness and understanding of both countertransference and reflective practice,
- Engaging in further research into countertransference by building on the findings of the current study.

Evaluation of the study

Although this research has provided a useful theoretical account on countertransference awareness development and the therapeutic relationship, it is acknowledged that all methods of research have limitations and therefore it is important that the limitations, as well as the strengths of the present study are given some consideration:

A key strength of the study is the empirical support it can offer to the substantial body of theoretical literature on the topic of enquiry. It is hoped that this will encourage further research in this area. Furthermore, the grounded theory presented provides a process model of the development of countertransference awareness and the therapeutic relationship, which was one of the main aims of the study and this has advanced understanding in this area in a way that is clinically useful in several domains, as discussed above.

Another positive outcome in the research journey was my own learning and development, which has deepened my own work, both academic and clinical.

While there are key strengths, there are also some limitations. There was the lack of diversity in the sample as the sample was made up of predominately white, female therapists. Given that the counselling context here is mediated by westernised theory and knowledge, it would have been useful to consider different contexts and understandings of the therapeutic relationship and countertransference from a non-western perspective. Also, participants who took part in the study did so because they had an interest in the topic, which may also have impacted the findings as they may have offered what they considered to be, socially acceptable or desirable responses. Furthermore, participant's transferential responses to the researcher and the researcher's countertransferential responses to the participants may have influenced what participants felt able to disclose.

Grounded theory it has been suggested is a time consuming and exhaustive process, which can lead novice researchers to become inundated at the coding level, where they can lose sight of the task resulting in lower levels of abstraction (El Hussein, Hirst, Salyers & Osuji, 2014). Because the analysis and data collection happened concurrently, this guarded against becoming inundated, furthermore because the grounded theory analysis was broken down into clear steps, i.e., coding, constant comparisons, theoretical sampling, this helped to contain the coding process.

Grounded theory has also been criticised for its lack of generalisability, as it is suggested that the knowledge produced may not be transferable to other groups and settings (El Hussein, Hirst, Salyers & Osuji, 2014). This was never the aim of the present study, which is why a social constructionist grounded theory methodology was adopted as it acknowledges that the findings, while they can offer a useful theory, they cannot claim to offer an objective picture of the topic under inquiry or claim to explain all the processes involved. That isn't to say that the findings are not helpful to those outside of the study, as, with any theory, it can illuminate processes, which occur in a variety of settings.

Skype Interviewing

The decision to use Skype as a method of interviewing was based on the assertion that Skype affords both the researcher and the researched, many benefits, for example access to a larger geographical area, flexibility and reduced research costs (e.g. Carter, 2011; Deakin & Wakefield, 2014; Hanna, 2012, Hamilton & Bowers, 2006; James & Busher, 2009; Seitz, 2016; Sullivan, 2012). As a student researcher, this was an attractive proposition, as access to wider geographical area enhanced recruitment opportunities, while keeping costs down to a minimum. While I was aware of the potential challenges, such as equipment failure, I was not prepared for the difficulties developing a rapport with participants when using this method.

In face to face interviewing, rapport and presence are understood to play an important part in minimising social distance, helping to establish trust, facilitating disclosure and a sense of intimacy in the research interview (Duncombe & Jessop, 2012). Currently there is some debate amongst researchers and authors on the development of rapport via a Skype interview, with some researchers and authors (e.g. Deakin & Wakefield, 2013; Hanna, 2012; Seitz, 2015) advocating that Skype can increase the development of rapport, as it can enable participants to be more open; remaining in their own environments is thought to facilitate a degree of safety and comfort. Furthermore, online interaction, according to Janghorban, Roudsari and Taghipour, (2014) can enable participants to express their true selves more fully and authentically due to the relative anonymity of online interviewing. This claim has been challenged by some researchers and authors (e.g. Carter, 2011; Seitz, 2016; Sullivan, 2012), who have suggested that technical glitches break up the flow of the narrative, creating a level of stress and distraction and inhibiting rapport. Furthermore, because Skype only offers a head shot, Carter (2011) suggests this can prevent some cues being fully observed, such as changes in emotion or signs of nervousness.

Using Skype for the current study impacted rapport for a few reasons. The technology broke down on several occasions disrupting the interview. The lack of natural eye contact left me feeling self-conscious and more aware of myself during the interview when compared to a face to face encounter, and as such, was a little distracting. As a therapist, the familiarity with face to face engagement may have also increased my level of discomfort, particularly when body cues and presence are core ingredients of therapeutic practice. Despite this, when reviewing the transcripts, the material seemed to be equally rich, as participants interviewed via Skype had made several important self-disclosures regarding their practice. Therefore, it is difficult to ascertain how much the difficulties impacted on the data or whether these participants would have made the same disclosures in a face to face interview. Therefore, it is difficult to draw any real conclusions on whether online interviewing increases disclosure due to its perceived anonymity, suggesting more research is needed in this area.

Meeting the criteria for a grounded theory study

There is general agreement that all research studies must be open to critique and evaluation. In keeping with the study's design, methods for evaluating a grounded theory study is based on the 4 key areas proposed by Charmaz (2006), credibility, originality, resonance and usefulness. Attending to these 4 key areas, the researcher believes that this study can be evaluated and critiqued at having met the criteria in the development of a grounded theory study. Ultimately, however, as Charmaz points out, 'it is the reader who judges the usefulness of the methods and the quality of the work' (Charmaz 2006, p182).

The credibility of the study is evidenced by the clear links that can be made between the analysis and the participant's data, which is illustrated through participant's quotes. The arguments that the study has put forward illustrate familiarity with the topic and are clearly supported by the data, the analysis and the literature, which offer a useful, conceptual explanation of the topic under enquiry.

The process diagram was also sent out for member checking, with participants confirming the diagram had captured their experience, which further confirms the credibility and rigour of the study. The findings presented above, have put forward 'containment' as a conceptual framework to describe how therapists can begin to develop their countertransference awareness, which previously was an unexplored research topic. Given that the absence of containing contexts depicts a worrying picture, as participants unwittingly acted out in the therapeutic relationship, reinforces and supports the relevance of containment in therapists on-going development and capacity to utilise their countertransference to the benefit of the therapeutic relationship. This makes an important contribution to the research literature; as the findings illustrate the pivotal role containing contexts play in reflective practice, which the findings suggest is key to developing countertransference awareness.

The findings also strongly challenge the premise that therapists do not need to attend to themselves, as when they fail to reflect on their inner world, they lack the required awareness to manage their countertransference in the therapeutic relationship. The findings, therefore, offer a useful theory on the development of countertransference awareness, which is both theoretically, and clinically useful as it can make an important contribution to the development of best clinical practice. While the findings make an important and useful contribution to counselling psychology and therapists generally, they also offer valuable insights into interpersonal dynamics, which can arise in any relationship.

Conclusion

The findings suggest that there is real benefit and utility in the development of countertransference awareness as it can enable therapists to manage their countertransference behaviour in the therapeutic relationship. The literature indicates that a lack of awareness of countertransference can have a negative impact on the client – therapist relationship. The findings support the literature in this area as well as adding important insights to the role awareness plays in the management of countertransference, by describing the process of containment and reflection. So, while reflection is crucial to developing self-awareness, including countertransference awareness, given that therapists in training encounter numerous internal and external stressors, they first need to feel contained. This is an important finding as it highlights therapists need to feel contained to engage in reflective practice. Conversely, the findings suggest when therapists fail to experience containment, in the face of such internal and external threats to self, it can result in defensive practice, acting out in the therapeutic relationship and a lack of personal development and self-awareness. It is therefore hoped that the findings of the present study can make an important contribution towards understanding how countertransference awareness can develop and how this development influences the therapeutic relationship.

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Does the development of countertransference awareness influence the therapeutic relationship? A grounded theory analysis.

Shelley Gait [1], Andrea Halewood [2] and Liz Maliphant [3].

[1] University of the West of England
[2] University of the West of England
[3] University of the West of England

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*Requests for reprints should be addressed to Andrea Halewood, Department of Psychology, School of life sciences, Frenchay campus, Coldharbour Lane, Bristol, BS16 1QY, United Kingdom. E-mail: andrea.halewood@uwe.ac.uk

Abstract

Objectives: The psychodynamic literature suggests countertransference is an inevitable part of therapy, and a significant feature of the client-therapist relationship. Often considered a 'double edged sword', it can be of benefit to clinical work when reflected on, however when outside of awareness it can be unwittingly acting out in the therapeutic relationship. This has led to a growing interest in the research literature in exploring the factors that enable countertransference to be identified and managed. While this research looks promising, with some key factors being identified, how countertransference awareness develops has yet to be explored. The purpose of this research was twofold, to explore the development of countertransference awareness and how this may or may not influence the therapeutic relationship and to construct a grounded theory of the process.

Design: The study adopted a social constructionist grounded theory methodology.

Methods: 15 qualified therapists were recruited and interviewed either face to face or via Skype, using a semi-structured interview.

Results: The grounded theory constructed from the data suggests that participants initially experienced countertransference as threatening and overwhelming. When the experience of overwhelm was contained in supervision, personal therapy, the organisational context and by an explanatory theoretical framework, participants could reflect and make sense of their countertransferential responses. This facilitated participants' growth and development, while supporting their engagement in the therapeutic relationship. Conversely a lack of containment in these domains resulted in participants becoming increasingly defended and acting out their countertransference to the detriment of the participant, the client and the therapeutic relationship.

Conclusions: These findings add support to the current literature on the role countertransference awareness plays in its management. The findings also suggest the role containment plays in this development. The implication of these findings, limitations of the study and avenues for further research are discussed.

Practitioner Points

- Training to be a counselling psychologist can be experienced as overwhelming
- Containing contexts enable the development of reflective practice necessary to develop countertransference awareness.
- Conversely a lack of containment can result in the adoption of defensive practices, including acting out unwittingly in the therapeutic relationship.

Introduction

The construct of countertransference, broadly defined as the therapist's emotional response to the client, has been discussed extensively within the psychodynamic literature (Gelso & Hayes 2007, Marroda 2004, Gabbard 2001, Ivey 2008, Coren 2015, Pope, Greene & Sonne 2006, Ligie & Gelso 2002, Burwell-Pender & Halinski 2008, Hayes 2004, Rosenberger & Hayes 2002). Initially considered as an impediment by Freud (1910), as it was understood as arising from the analyst's unresolved dynamics, which could lead to an emotional entanglement and a distorted understanding of the client. It was later expanded in the 1950's by among others, Heimann (1950), who took the view that countertransference feelings in the therapist were unavoidable, and while they could be disturbing, they could also yield valuable information about the internal world of the client. As a result, the totalist perspective legitimised and normalised therapists' responses and countertransference came to be viewed as useful and worthy of further investigation (Dahl, Rossberg, Bogwald & Hoglend, 2012; Holmes & Perrin, 1997; Mills, 2004). This position was further developed by a number of relational theorists who constructed countertransference as an interpersonal phenomenon arising within the client and therapist interpersonal dynamics (Mitchell 1988, Aron 1990). While agreeing that the countertransference offers valuable information on the client, relational theorists argue that it also reveals much about the analyst and the analytic relationship (Bass, 2015). The role of the analyst was therefore to decipher and identify the contribution of both parties in the therapeutic dyad (Money-Kyrle, 1956).

This reflects the post-modern turn, which has seen a fundamental change in psychoanalytical thinking, which advocates that people are relational beings, and therapy is therefore an inter-subjective encounter (Risq 2010, O'Brien 2010, Milton 2011). Today it is generally agreed amongst psychodynamic theorists and practitioners that countertransference, is an inevitable and central part of therapy (Marroda 2004, Gabbard 2001, Zachrisson 2009, Ivey 2008, Coren 2015, Gelso & Hayes, 2007; Pope, Greene & Sonne 2006, Ligie & Gelso 2002, Hayes 2004), which, if reflected on and understood, benefits the therapeutic relationship. Conversely, unmanaged countertransference can result in a negative therapeutic outcome.

The development of countertransference awareness

Reflective practice is central in countertransference awareness, it requires a motivation and willingness to consider professional experiences in general as well as the challenges that arise (Bennett-Levy, Turner, Beaty, Smith, Paterson & Farmer 2001). While the literature on reflective practice emphasises its importance, there has been less attention given to the conditions, which enable reflective practice to take place. It has been suggested that clinical supervision, which offers the opportunity to reflect on the relationship between therapist and client, supports the development of countertransference awareness (Pakdaman, Shafranske & Falender, 2015; Burwell-Pender & Halinski, 2008; Kumari, 2011; Watkins 1985). Clinical psychologists Pakdaman, Shafranske and Falender (2015) suggest that supervision may be the only place where difficult and challenging feelings and responses can be discussed. There is also some empirical support for the role personal therapy can play in developing countertransference awareness. Bike, Norcross & Schatz (2009) conducted an extensive survey of 600 psychologists, counsellors and social workers, personal therapy was described as helping in increasing awareness of personal dynamics, client-therapist interpersonal dynamics and countertransference awareness. Furthermore, participants said it also enhanced their presence, tolerance and empathy within the therapeutic relationship.

Barriers to developing countertransference awareness

While reflective practice is suggested to play a role in developing self-awareness in therapists, there has been some suggestion within the literature that trainees encounter a number of internal and external barriers, which impact their ability to reflect. It is observed that the developmental journey can be particularly difficult for therapists in training, because in comparison to more experienced therapists, the trainee therapist has yet to develop the necessary experience, self-awareness and reflective skills which would enable them to manage their anxiety and overwhelm. (Marroda 2012, Skolholt & Ronnestad 2003, Hill, Sullivan Knox & Schlosser 2007, Theriault, Gazzola & Richardson 2009, Truell 2001, Stefano et al 2007). Research has shown that trainees in particular can struggle with in-session awareness of their affective & emotional states, as these can increase a sense of overwhelm making it difficult to remain engaged with the client (Williams, Polster, Grizzard, Rockenbaugh & Judge 2003, Theriault 2009, Nutt-Williams & Hill 1996). Fauth & Hayes (2006) suggest countertranferential overwhelm can result when the experience is subjectively appraised as threatening in some way. This can then lead to fears of being judged and criticised in supervision as trainees fear their perceived incompetence indicates they are unsuitable for the profession (Yourman and Farber 1996, Yourman 2003, Skovholt & Ronnestad 2003).

The above literature seems to suggest the experience of internal and external barriers seems to diminish opportunities to engage in reflection, key to developing countertransference awareness. Therefore, what enables the development of countertransference awareness seems an important avenue of enquiry.

Research aims

The aim of this research is twofold: to explore therapists' developing countertransference awareness and how this may or may not influence the therapeutic relationship and to develop a grounded theory of this process. The study also aims to make a useful contribution to the existing literature on countertransference as well as clinical practice.

Method

It has been suggested that positivist quantitative methods are not suitable for the study of some aspects of human experiences (Hoyt & Bhati, 2007; Polkinhorne, 2005) and that qualitative methodologies are more suited to clinical practice, as they take account of, and capture, human experience (Cresswell, 1998). Adopting a qualitative methodology is therefore considered to be particularly suited to the study of psychotherapy processes; as this method of enquiry acknowledges the subjective and interpretative nature of meaning, which is a significant element in the practice of psychotherapy (Rennie, 1994; Hansen, 2004). According to Mills, Bonner & Francis (2006) when choosing a research paradigm, it is important to remain 'congruent' with one's own beliefs about the nature of reality as this will ensure a coherent research design. A social constructionist methodology seemed particularly appropriate for counselling psychology research, as both are concerned with intersubjective process, and the ways in which people engage and interact together (Mahoney & Neimeyer, 1995; McNamee, 2004). Furthermore, because the researcher's subjectivity cannot be separated from the research process, methods of enquiry are needed which acknowledge that meanings and understandings are not objectively discovered but constructed through the research process (Luca, 2016). Reflexivity therefore is an important part of the research process as it emphasises the importance of the researcher turning the lens back on oneself (Kacen & Chaitin, 2006), to become aware of one's own place and influence on the whole research process (Berger, 2015).

Design

This was a qualitative study using semi-structured interviews and a constructionist grounded theory methodology (Charmaz, 2006, 2008). This methodology has been identified as particularly suited to counselling psychology and psychotherapy research as it focuses on process, actions and meanings in a particular context (Morrow, Castaneda-Sound & Abrahams 2012, Charmaz 2006, 2008).

Participants and Recruitment

15 qualified therapists were recruited to the study. Initially a purposeful sampling strategy was utilised to recruit 8 participants who met the inclusion criteria of a) a recognised qualification in a school of therapy, e.g. counselling psychology, counselling, psychotherapy; b) at least one year's clinical experience of working one-to-one with clients, c) some awareness of the construct of countertransference, there were no explicit exclusion criteria. In accordance with the GT method a further 6 participants were recruited using a theoretical sampling strategy (see Appendix A for demographic information). Information regarding the study was posted on several sites; The British Psychological Society (BPS) division of counselling psychology (DCOP) website and Counselling Psychology and Counselling & Psychotherapy sites on Facebook, JISCMAIL a free online email database and LinkedIn, a professional networking site. Participants who expressed an interest in taking part were sent an information sheet and a consent form, time, date and location of the interviews were then agreed via email.

Interviews

Interviews were conducted face to face and online via Skype. Participants were asked about how their countertransference awareness developed and whether or not this awareness had influenced the therapeutic relationship using clinical examples to illustrate the process of development. Each interview lasted up to one hour and was audio recorded. The interviews were transcribed, and saved

onto a password, protected computer. The original recording was then deleted.

Data analysis

The interviews were transcribed and then analysed using the grounded theory method outlined by Charmaz (2006, 2008, 2011). Initially each line of data was open coded to capture actions. Then larger segments of data were coded to develop more abstract and focused codes; using the method of constant comparison codes were compared with codes across interviews to develop categories. Memos & diagrams were used to capture ideas, theoretical links, relationships, differences and responses to the data and the codes. Theoretical sufficiency was considered to be reached when the pre-existing categories were sufficient to capture the new data obtained through further sampling and analysis.

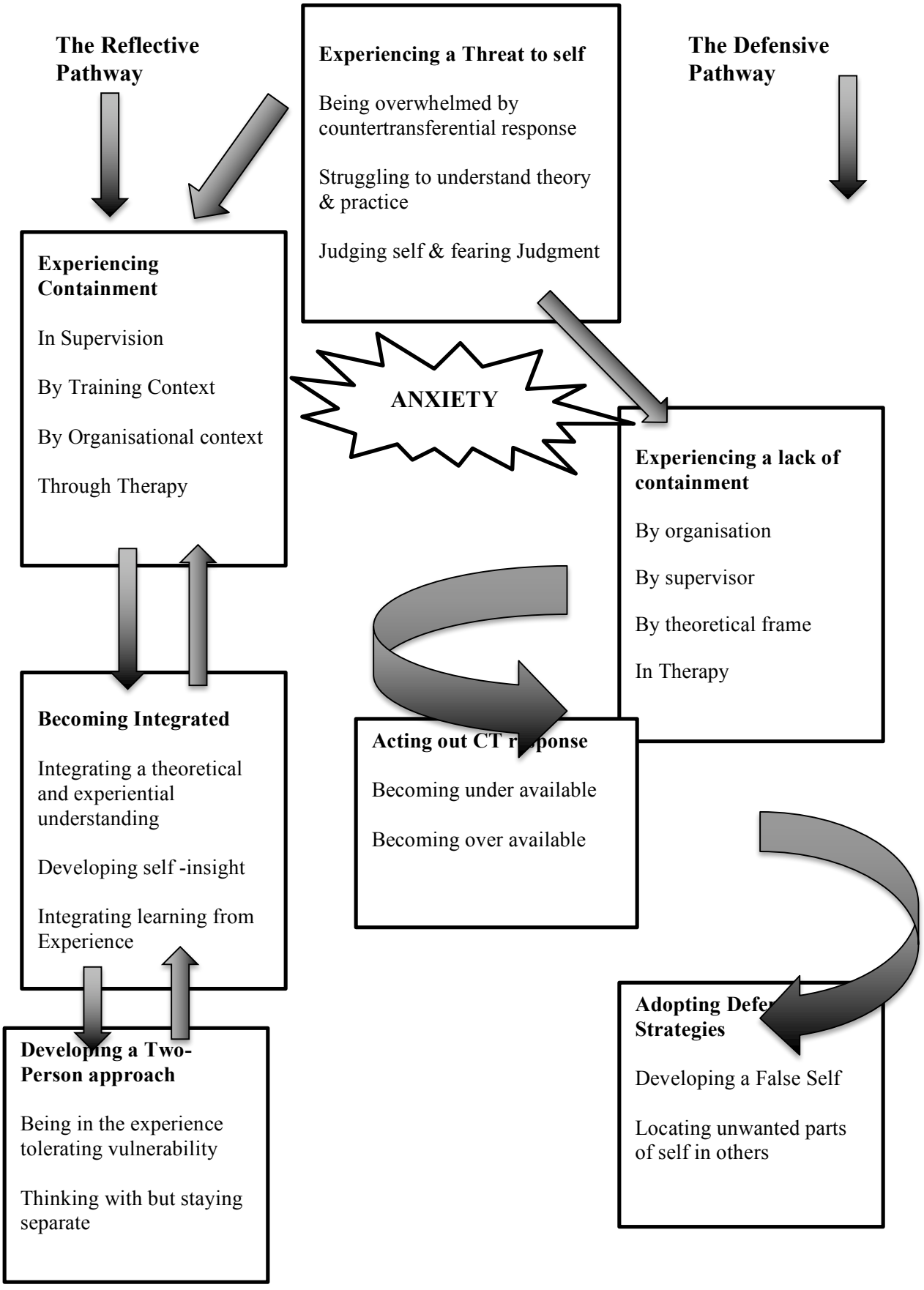
Ethical consideration

Ethical approval was obtained from the University of the West of England Research & Governance board. Participants were informed that they had the right to withdraw at any time; confidentiality was ensured subject to the limitations outlined by the BPS.

Findings

The grounded theory constructed from the data indicates that developing awareness of countertransference and its subsequent management is not an easy task for therapists in training. Participants experienced several threats to self during this process, which led them to progress along one of two pathways, *a reflective pathway* and *a defensive pathway*. Depending on the degree of containment they were provided with was central to their adoption of one of these pathways. This article will focus on the reflective pathway of the diagram depicted below after briefly outlining the threats to self.

Fig 1: Process Diagram of grounded theory of countertransference awareness development and the Therapeutic Relationship



Experiencing a Threat to self

Being overwhelmed by countertransferential response

Participants experienced their countertransferential responses as overwhelming and threatening. Many felt unprepared for the emotional responses the client's material and behaviour evoked in in them:

He had this enormous sense of power about what he was saying and I felt very frightened at the time" Participant 1 [female, psychologist working in private practice].

"It was quite scary I remember her being quite, not her being but the work being quite scary in terms of it being my first sort of experience" Participant 3 [female, psychotherapist working in CAMHS service].

Struggling to understand theory and practice

Being introduced to the theoretical construct of countertransference in advance of working with clients was similarly problematic as it was a difficult concept to understand without experience. This led to further anxieties and self-criticism:

"I remember feeling quite stupid because it's so fundamental to the work and I don't understand it" Participant 9 [female, integrative psychotherapist working in private practice].

Judging self-fearing Judgement

Lacking either a theoretical or experiential understanding of countertransference at the outset of their training, participants struggled to make sense of their responses to their clients, which were instead constructed as an indication of incompetence:

"I felt pulled to him and I felt really bad, I thought I'm being really unprofessional, you know having some kind of feelings for someone" Participant 2 [female, psychological therapist & trainee counselling psychologist working in the NHS].

Participant's feelings and responses when they didn't fit with how they believed a therapist should behave led to self-criticism, and a fear that their personal failings & incompetence, would be exposed resulting in them being judged as not up to the role of therapist:

"I didn't want to look weak, I didn't want to look like the therapist in training, who hadn't sorted her own stuff" Participant 9 [female, integrative psychotherapist working in private practice].

As participants progressed through their training they began to follow one of two pathways, a reflective pathway or a defensive pathway, which pathway participants followed appeared to be dependent on whether they had a containing framework in place.

The Reflective pathway

Experiencing containment

A critical component of a containing framework was that it offered participants a space and time to reflect on their countertransferential responses. Supervision, the training and organisational contexts, trainee's theoretical framework and personal therapy were all identified as performing a containing function.

In supervision

The supervisor's response to the sharing of clinical material seemed to be a

critical; this enabled participants to experience supervision as a supportive, safe and trusting space; one where they didn't fear judgment as where their experiences were normalised and understood:

"I was really embarrassed to take it there…by actually talking about it and kind of understanding what was going on..I could.., I could see it in a different way.. I didn't feel embarrassed as I understood it" Participant 2 [female, psychological therapist & trainee counselling psychologist working in the NHS].

This seemed to foster a strong alliance enabling the more difficult aspects of the work to be shared and considered which helped participants to move away from feeling shamed, incompetent and defensive Furthermore, the supervisor's response seemed to stimulate participant's interest in, and curiosity about, their countertransferential material, enabling them to develop both their emotional and intellectual awareness:

"this sense that not only that I should take everything but I can..at the same time it's a feeling on my part I want to know" Participant 10 [female, integrative counsellor working in private practice].

Training contexts

Countertransference development was also supported by training contexts, which privileged an attendance to countertransference by offering both a guiding framework and opportunities for reflection on countertransferential responses:

"I would say..by virtue of my training countertransference has become one of the key aspects of my practice" Participant 5 [female, psychodynamic therapist working in a university setting].

"I have got the breadth of theory that gives you the sense making explanation and the vocabulary to actually be able to describe what I am

experiencing" Participant 10 [female, integrative counsellor working in private practice].

Organisational contexts

Some participants worked in contexts where attendance to countertransferential material was part of the organisational culture, and where there was an expectation and requirement to participate in reflective practice, including attendance to countertransferential material:

"We have once a week clinical meeting as a way to think about client, um try to see what comes up from, you know different people and we think we are picking up different things" Participant 5 [female, psychodynamic psychotherapist working within a university counselling service]

Personal therapy

For some participants, their personal therapy offered a space for reflection, enabling them to recognise and separate out their own dynamics and material from that of their clients:

"to have the therapeutic work on yourself so you know what your own material is and then you can join up the dots" Participant 4 [female, psychotherapist working in private practice].

Becoming Integrated

Containment appeared to increase participants' capacity for self-reflection and reflection on the work, leading to a developing integration of their theoretical and experiential learning.

Integration of a theoretical and experiential understanding of countertransference

Participant's ability to make connections between theory and experience seemed to enable the integration of a theoretical and experiential understanding of countertransference. This ability increased participant's capacity to pay attention to their experience in the room with their clients, as well as their curiosity about this experience:

"I have to stop and say to myself what's going on here, why I am I feeling this particular feeling, how does it relate to what the clients feeling and how does it relate to what I'm feeling. Is it mine, is it theirs" Participant 1, [female, psychologist working in private practice].

Development of self-insight

Increasing levels of self-awareness facilitated the participant's development of self-insight, which increasingly enabled participants to differentiate between their own dynamics and that of their client's:

"You're constantly having to think what's happening for the client, what's happening for you and then kind of how those two link and what belongs to them, what belongs to you" Participant 3 [female, psychotherapist working in CAMHS service].

Becoming more aware of their feelings, motivations and relational dynamics in their own therapy, in supervision and in their clinical work enabled participants to begin to repair and change the way they approached the work:

"my awareness built up more into thinking about my responses and my physical feelings, my emotions and everything that went on with a client and how that kind of might impact my history, things that I have learnt over my childhood and slightly different things" Participant 2 [female, IAPT Psychological Therapist & Trainee Counselling Psychologist working in the NHS].

Integrating learning from experience.

Participants 'commitment to, and engagement with, ongoing reflection even after the client work had ended opened up the possibility of ongoing development as they began integrating their learning through engaging in reflection. Participants' motivation to learn from the experience enabled them to develop their countertransference awareness retrospectively, which they were than able to use for the benefit of the work:

"I felt she was really trying to run the show in a big way. I didn't particularly like that in her…the thing I missed was those are all traits in me, that I don't like, (laugher)…. I think it would have been more successful, if I had owned that bit of me my relationship with her would have been different" Participant 9, [female, integrative psychotherapist working in private practice].

Developing a Two-person approach

An outcome of being on the reflective pathway was the move away from what initially appeared to be a one-person to a two-person approach.

Being in the experience tolerating vulnerability

While participants experienced clinical work as deeply uncomfortable at times, their developing countertransference awareness increased their ability to remain present for their clients and tolerate their own discomfort:

"there is something to be said for sitting with the discomfort, but also really trying to unravel it" Participant 10 [female, integrative counselor working in private practice]

Participants' capacity to sit with the vulnerability in the room enabled them to attune to the client, which allowed for a deeper understanding to develop within the therapeutic relationship:

"I think you have to be caught up in it, sometimes to understand it, you have to be in the experience" Participant 12 [female, psychotherapist and supervisor working in the NHS mental health services and private practice].

Thinking with but staying separate from

Participants developed the capacity for dual awareness, as they could listen to their clients and to their own countertransferential responses simultaneously. This dual process appeared to be critical in helping participants to manage their own countertransference as it arose in the therapeutic relationship.

"I'm listening to how I feel, how I see the client responding to how I am and using that as a way of understanding better where it is that their coming from" Participant 1 [female, psychologist working in private practice].

Participants were then able to offer the client an interpretation of the experience, which had been cognitively processed, which enabled the meaning to be reflected on rather than acted out:

"For a while I think I was caught up in that and responding in countertransference and perhaps in a less productive way. Until I really sat and thought about it and spoke about it with my supervisor and went aah this is her this isn't me…I was able then to say to her…I'm wondering if this is something that you feel like exists in your life" Participant 3 [female, psychotherapist working in CAMHS service].

Discussion of the findings

The findings indicate that developing awareness of countertransference is not an easy task for a therapist in-training, who can feel unprepared for the challenges and realities of the work. As a result, they can struggle to remain present in the therapeutic relationship, as they became caught up in containing their own powerful emotions. The existing research and theoretical literature indicates feeling overwhelmed, as a trainee therapist is not unique to the participants in this study, with many trainees reporting they felt ill equipped to respond to another's distress, and that they frequently felt distracted and overwhelmed by their internal affective states (Hill, Sullivan Knox & Schlosser 2007, Theriault 2009, Cohen & Hatcher 2008, Truell 2001, Polster, Grizzard, Rockenbaugh & Judge 2003, Nutt-Williams & Hill 1996, Cartwright, Rhodes, King & Shires 2014). When this resulted in defensive disengagement from the client, it was constructed as an indication of incompetence, with trainees doubting their therapeutic abilities. Feelings of incompetence it has been suggested arise because trainees have unrealistic expectations such as they should always know what to do, always be affective, warn and empathic (Casement 1985, Truell 2010, Kumary & Baker 2008, Stefano, D'luso, Blake, Fitzpatrick, Drapeau & Chamodraka 2007). Because trainees fail to understand being impacted by the client is a normal and expected aspect of the work, when they fail to meet their expectations, they feel, ineffective, inadequate, helpless and overwhelmed (Burwell-Pender & Halinski 2008, Truell 2001, Skovholt & Ronnesatd 2003). Interestingly learning psychodynamic theory did not reduce participant's fears around incompetence, it added to them, as participants struggled to both understand the theory and apply it to practice, while remaining engaged with the client. The findings of the present study add to the literature as in the absence of an alternative understanding trainees felt compelled to hide or get rid of their vulnerabilities, as it was feared if revealed they would be judged as an indication they were unsuitable for the profession.

The psychodynamic literature suggests that a major barrier to reflective practice can be the adoption of defensive strategies to deal with the emotionally charged

nature of the therapeutic encounter (Pietroni, 1995). Bion's (1961), theory of containment suggests that for reflective practice to be possible, 'containers' need to be provided, which offer the appropriate physical, mental and emotional space, required to engage in reflection. Containment therefore offers a conceptual framework for understanding how participants in the present study faced, understood and effectively thought about their countertransference, rather than defensively discharging it.

Within the counselling and psychotherapy literature, it is suggested supervision is often where therapists first begin to develop their countertransference awareness (Pakdaman, Shafranske & Falender 2015), a suggestion that is supported by the findings of the present study. Pope, Greene & Sonne (2006) highlights that a sense of safety and basic trust in the integrity of supervision is essential as to explore topics, which may feel 'taboo', or threatening in some way, involves taking a risk on the part of the supervisee. They suggest that the notion of safety comes from the knowledge that what is shared will not be a threat to the personal and professional self (Pope, Greene & Sonne 2006). The containing supervisor it is suggested is analogous s to Winnicott's 'good enough mother' (1956, 1960) offering a facilitating environment to 'hold' and empathise with the trainee's clinical experiences, while they engage with in the work. Winnicott suggests that (1956,1960), much like the mother, the supervisor's provision of a holding environment provides a 'container', where the 'unbearable' experience, can be made more tolerable. In effect the supervisors mind offers a containing function, which transforms the threatening material into a meaningful experience (Stewart 2004).

The present study adds considerable support for the central role of the supervisory process in developing countertransference awareness and in offering a containing function to enable countertransference feelings and responses to be reflected on and given meaning. Without a containing supervisor, participants were unable to reflect and consider their countertransferential material, which resulted in defensive strategies and unwittingly acting out their countertransference in the therapeutic relationship. Countertransference

awareness was also identified by participants' as developing in personal therapy as this offered a space for the exploration of material evoked by the work, which often seemed to lead participants to reintegrate previously disowned parts of the self. There is some support in the wider literature on the benefits of personal therapy in developing self-awareness. According to Kumari (2011) personal therapy can help therapists gain more insight into interpersonal dynamics by increasing self-awareness in the therapeutic relationship. Kumari suggest that personal therapy can aid therapist in separating out his or her own issues from those of the clients and in doing so, reduces the possibility of counter transference reactions. There is some debate in the literature on whether personal therapy should actually be mandatory for therapists in training as according to some authors there is no proven benefit to therapists engaging in personal therapy and client outcomes (Clarke 1986, Atkinson 2006).

The findings of the present study seek to challenge this assertion; participants in the present study used their personal therapy to develop awareness of their own dynamics, which led to personal and professional development, with participants more able to identify their countertransference when it arose in the work. Given that personal therapy can develop therapist awareness and insight into their own dynamics, these findings would seem to suggest that it is beneficial to client outcomes if it enables therapists to manage their countertransference behaviors rather than acting out unwittingly within the therapeutic relationship. Perhaps the disparity in findings suggests that for therapy to be effective, it needs to be experienced as containing.

The experience of containment enabled participant to begin to move away from feeling of incompetence as they began to develop a framework, which helped them to develop and make sense of their countertransferential feelings and responses, which supported the development of self-insight, self-acceptance and personal growth. These findings are consistent with research carried out by Hayes, Gelso, Wagoner & Diemer (1991), which suggest that therapists who developed insight were more able to identify and recognise their own thoughts, feelings and behaviours, and therefore were less likely to misattribute these to

their clients, a critical component in developing a two-person approach to the work. In contrast the findings suggest when there is an absence of a container, who can offer a boundaried, safe space where the experience can be digested and transformed, with no way of containing the experience, the uncontained individual has no choice but to defend against what is experienced as harmful (O'Connor 2006). Furthermore, without the experience of a containing other, the individual has not internalised the capacity to contain and therefore cannot draw upon this to manage anxiety when and if, it arises (O'Connor 2006). The findings indicate that participants on the defensive pathway acted out in the therapeutic relationship, which seemed to undermine the work with the client.

Implications of the findings for practice

The grounded theory presented above indicates the role reflective practice plays in developing countertransference awareness and the role containing factors play in supporting this. These findings are significant for the field of counselling psychology, which constructs reflective practice as part of its professional identity (Woolfe, 2012). This is reflected within the Counselling psychology divisional practice guidelines (2005) which outline counselling psychologists' responsibility to avoid doing harm to clients by being able to identify, understand and manage their own responses by engaging in reflective practice. These guidelines clearly place a responsibility on the practitioner to recognise and manage their countertransference by developing their self-awareness through reflective practice. However, in practice the engaging in reflective practice is a challenging process, particularly for trainees who can struggle to cope with the impact of the client and realities of learning to do therapy. Considering being impacted by the client was a common experience, underscores the importance of the provision of containment in the trainee's capacity to engage in reflective practice. This indicates therefore for reflective practice to occur, therapists need to feel adequately contained, which places a responsibility on all those involved in the work of therapy.

Training and Supervisory context

The findings illustrate that the experience of containment is made possible when training programmes and supervisors, attend to trainee's anxieties and vulnerabilities, which can be evoked through the work and when learning to be a therapist. As when trainee's experiences were normalised and given meaning, this provided a level of containment, it supported them to deal with the realities of the work, while also shaping a professional identity where vulnerability and limitations could be tolerated. Therefore, the findings suggest to develop countertransference awareness so it can be managed to benefit of the work, first requires a culture of containment at a training level, which is also supported in supervision.

Personal Therapy

The findings clearly illustrate that therapists own relational dynamics and vulnerabilities were evoked in the client-therapist relationship, which adds considerable support to the need to engage with personal therapy as a mandatory training requirement for counselling psychology. The findings suggest therapists who had developed self-insight through personal therapy felt more equipped to manage their countertransference when it arose in the work. This is supported by the wider literature discussed above which suggest that that the more aware a therapist is of their own dynamics, wounds, needs and motivations, the less likely these will impact the work. This has important implications for the role therapy can play for therapist in training, and adds support to the current debate on whether counselling psychologists and therapists generally need to engage in personal therapy

Organisational context

The findings illustrate the struggles faced by counselling psychologists and therapists who work in environments, which don't offer opportunities to engage in

reflective practice regarding interpersonal dynamics arising in clinical work. Given that counselling psychologists are increasingly working in these environments this presents counselling psychologists with a challenge; how to hold onto the values of counselling psychology, which privileges both reflective practice and attention to the therapeutic relationship while working in a service, which focuses on targets and outcomes. The importance of cultivating practitioner self-awareness is central in Counselling Psychology. The recent Health Professions Council's 'practitioner psychologists' guidelines (2009) emphasise how the Counselling Psychologist, in particular, must be able to 'critically reflect on the use of self in the therapeutic process'. The guidelines make clear that the individual practitioner has a responsibility to cultivate and maintain an awareness of their self. Yet what these guidelines do not address is how to manage the tension between the humanists and relational values of counselling psychology, when working in contexts, which espouse a rationalist and medical approach (Blair 2010, Chwalisz 2003). This raises an important ethical dilemma, because the findings of the present study indicate that reflective practice and attending to interpersonal factors are critical to countertransference awareness, and its management.

Directions for future research

It would be fruitful to build on the findings to research how countertransference is taught in different schools of therapy and how this relates to awareness and management of countertransference. It would also be useful to explore how different therapist engage in developmental work and reflective practice and whether there are difficulties and/or limitations of assimilating the construct of countertransference into different theoretical perspectives. Given that context for participants played such an important part in how contained they felt, future research in this area would be hugely beneficial to explore the impact in more detail of working in un-containing contexts on the therapist and on the client.

Limitations of the research

It is acknowledged that all methods of research have limitations and therefore it is important that the limitations of the present study are given some consideration. There was the lack of diversity in the sample as the sample was made up of predominately white, female therapists. Participants who took part in the study did so because they had an interest in the topic, which may also have impacted the findings as they may have offered what they considered to be socially acceptable or desirable responses. Furthermore, participants' transferential responses to the researcher and the researcher's countertransferential responses to the participants may have influenced what participants felt able to disclose.

Conclusions

The findings suggest that countertransference awareness enables therapists to manage their countertransference behaviour in the therapeutic relationship. The literature indicates that a lack of awareness of countertransference can have a negative impact on the client-therapist relationship. The findings support the literature as well as adding important insights to the role awareness plays in the management of countertransference, by describing the process of containment and reflection. So, while reflection is crucial to developing self-awareness, including countertransference awareness, given that therapists in training encounter numerous internal and external stressors, they first need to feel contained. This is an important finding it highlights therapists need to feel contained to engage in any form of reflective practice. Conversely the findings suggest when therapists fail to experience containment, in the face of such internal and external threats to self, it can result in defensive practice, acting out in the therapeutic relationship, a lack of development and self-awareness

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Appendix - Participant's demographics are listed in the table below.

Participant	Gender	Occupation/therapeutic approach
P1	Female	Psychologist / private practice
P2	Female	Psychological Therapist IAPT / trainee counseling psychologist
P3	Female	Psychotherapist / CAMHS
P4	Female	Psychotherapist - Humanistic & Integrative / Private Practice
P5	Female	Psychodynamic Psychotherapist – Psychoanalytic / University counseling service
P6	Female	CBT therapist / trainee counseling psychologist
P7	Male	Integrative Counsellor / trainee counseling psychologist
P8	Female	Counsellor & Psychotherapist – psychodynamic / University counseling service
P9	Female	Integrative psychotherapist / trainee counseling psychologist / private practice
P10	Female	Integrative counsellor / private practice
P11	Male	Psychotherapist / Supervisor / private practice
P12	Female	Psychotherapist / Supervisor / Mental Health service / private practice
P13	Female	Psychological Therapist IAPT / integrative counsellor / private practice
P14	Female	Counselling Psychologist & Supervisor / private practice
P15	Male	CBT Psychological Therapist IAPT

APPENDIX SECTION

A. Participants Demographics

B. Participant information sheet

C. Consent form

D. Debrief

E. Interview questions

F. Constant Comparison example

G: Memo example

H: Example of earlier Diagram

I: Member checks examples from Participants

J: Project certificate Information regarding chosen journal

K: Extract of coded interview

Appendix A: Participants Demographics

Participant (P)	Demographics	Occupation/therapeutic approach
P1	Female	Psychologist / private practice
P2	Female	Psychological Therapist IAPT / trainee counseling psychologist
P3	Female	Psychotherapist / CAMHS
P4	Female	Psychotherapist - Humanistic & Integrative / Private Practice
P5	Female	Psychodynamic Psychotherapist – Psychoanalytic / University counseling service
P6	Female	CBT therapist / trainee counseling psychologist
P7	Male	Integrative Counsellor / trainee counseling psychologist
P8	Female	Counsellor & Psychotherapist – psychodynamic / University counseling service
P9	Female	Integrative psychotherapist / trainee counseling psychologist / private practice
P10	Female	Integrative counsellor / private practice
P11	Male	Psychotherapist / Supervisor / private practice
P12	Female	Psychotherapist / Supervisor / Mental Health service / private practice
P13	Female	Psychological Therapist IAPT / integrative counsellor / private practice
P14	Female	Counselling Psychologist & Supervisor / private practice
P15	Male	CBT Psychological Therapist IAPT

Appendix B: Participant Information Sheet:

Does the development of therapists' 'countertransference awareness' influence the therapeutic relationship?

You are being invited to take part in a research study. Before you decide whether or not you wish to take part, it is important for you to understand why the research is being conducted and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Thank you for reading this.

Who are the Researchers

I am Shelley Gait a fourth year trainee Counselling Psychologist on the Professional Doctorate programme in Counselling Psychology at the University of the West of England. I am completing this research as part of my training. The research is being supervised by Andrea Halewood, a senior lecturer on the programme, and Victoria Clarke, an Associate Professor in the Department of Psychology, with expertise in qualitative research.

What is the purpose of the study?

I am interested in exploring countertransference awareness and how this may or may not influence the therapeutic relationship. Although a number of studies have alluded to this, there have been no studies to date that have focused specifically on this question. Therefore this study aims to expand the evidence base on countertransference and the therapeutic relationship.

Who is eligible to participate?

You are eligible to participate if you answer yes to the following statements:

1. If you hold a recognised qualification in for example Counselling Psychology, Clinical psychology, Counselling, Psychotherapy or CBT.
2. If you have some understanding of countertransference
3. Can reflect on whether it influenced the therapeutic relationship
4. You can reflect on two clients one where you had not developed countertransference awareness and one where you had.
5. You are no longer working with the clients you discuss

Do I have to take part?

Taking part in this study is entirely voluntary, so it is up to you to decide whether or not to take part. If you do agree to take part you will be asked to complete a consent form. If you decide you want to withdraw from the research after participating in the interview, please contact Shelley. Please note that there are certain points beyond which it will be impossible to withdraw from the research for instance, when we have published papers reporting our analysis of the data. Therefore, we strongly recommend that you contact Shelley *within a month* of participation if you wish to withdraw your data. If you do decide to withdraw from the study before the report has been submitted any information you have shared with me will not be used in the study and will be deleted. To withdraw from the study all you have to do is email me giving your ID number, which can be found at the top of your Participant Information Sheet and your data, will be removed from the study.

What will happen to me if I take part and what do I have to do?

If you agree to take part you will be asked to

- Attend an interview at a location convenient to you
- Or if you prefer online via email or Skype
- The face-to-face interviews will last around an hour although you will need to allow around up to 90 minutes in total for participation.
- The face-to-face or Skype interviews will be audio-recorded.
- The audio-recordings will be transcribed and typed up for the purposes of analysis.
- With the email interviews you will be sent the questions to answer to be returned via email within 2 weeks of the questions being sent.
- In whatever interview you participate you will be asked to reflect on your clinical work, the development of your countertransference awareness and how this may, or may not, have influenced the therapeutic relationship.
- You will also be asked to complete a short demographic questionnaire, this is to provide background information on your training and qualifications and to help me understand the range of people taking part in the study
- We will discuss the content of this form at the start of our meeting, and you will be given an opportunity to ask any questions you have about the study before completing the consent form and starting the interview.
- You will be given a further opportunity to ask questions after we have completed the interview.

How will the data be used?

The data will be used for my research. The transcript of your interview will be anonymised so any information that can identify you such as name, place etc. will be removed. Once anonymised, the data will be analysed for my research, and anonymised extracts from the data may be quoted in my thesis and in any publications and conference presentations arising from the research. The demographic data for all of the participants will be compiled into a table and reported in my thesis and in any publications or presentations arising from the research. Agreeing to take part in this research means that you agree to this use of the information you provide.

What are the possible disadvantages and risks of taking part?

It is important to be aware that reflecting on your experience could cause you some distress; therefore it is important you only share what you would be happy for someone else to know about you. Your identity, and any information about your clients, will be kept completely anonymous so nobody other than the researcher will be able to link what you have shared with who you are. If you find you need some emotional support at any time then you can either speak to me or my supervisor, or one of the following would also be able to provide support or further information of where support can be accessed.

1. British Psychological Society: 0116 254 9568
2. British Association of Counselling and Psychotherapy: 01455 883300

What are the possible benefits of taking part?

Although there are no direct benefits to you in taking part, you may find it useful to reflect on your experience. You will also be contributing to an under researched area and the findings of this study may be beneficial to others.

What if something goes wrong?
If you are unhappy with any aspect of the study you can contact my primary supervisor whose details are below.

Andrea Halewood
Department of Psychology, Faculty of Life and Health Sciences
Frenchay Campus, Coldharbour Lane
Bristol, BS16 1QY
Email: Andrea.Halewood@uwe.ac.uk
Tel: 0117 3283889

Will my taking part in this study be kept confidential?
All information shared will be password protected and my supervisors and I will be the only people who will be able to access the information in full. All information about you will be completely anonymised, so your name or any other identifiable information will be removed or replaced, so there will be no way of linking what you have said back to you. Following the study all primary data sources will be deleted.

It is important that you are aware that before agreeing to take part that if you share any information which breaches ethical codes of practice as set out by the BACP and the BPS I will be obliged to break confidentiality. These codes can be accessed via the links below and is important that you are familiar with them before taking part.

http://www.bacp.co.uk/ethical_framework

http://www.bps.org.uk/what-we-do/ethics-standards/ethics-standards

What will happen to the results of the research study?
I will write up a report at the end and this will be read by my peers, the university and may be published by a journal. If you are happy to give me your email address I will inform you via email where you can access the study.

Contact for further information
You can contact me on the following email: **Shelley.Zagwojska@live.uwe.ac.uk**

Taking Part
If you wish to participate please contact me: Shelley.zagwojska@live.uwe.ac.uk.

Thank you for taking the time to read this information sheet.

Appendix C: Consent Form for the following study

Does the development of therapists' 'countertransference awareness' influence the therapeutic relationship?

Shelley Gait
Trainee Counselling Psychologist
Shelley.Zagwojska@live.uwe.ac.uk

		Please initial box
1.	I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.	☐
3.	I agree to take part in the above study.	☐

		Please tick box	
		Yes	**No**
4.	I agree to the interview being audio recorded	☐	☐
5.	I agree to the use of anonymised quotes in publications	☐	☐

:

Name of Participant typed	Date	Signature
Name of Researcher typed	Date	Signature

Appendix D: Debrief Sheet for the Study:

Does the development of therapists 'countertransference awareness' influence the therapeutic relationship? : A grounded theory exploration.

Thank you for taking part in this study; if you have any questions about the study or would like to say anything about your experience of participating then please feel free to discuss this with me.

If you have any comments or concerns about the study, please email me at: Shelley.zagwojska@live.uwe.ac.uk

or you can contact my supervisor at andrea.halewood@uwe.ac.uk

I am providing details of the following organisations for your convenience should participation in this study have caused you any distress:

1. British Psychological Society: http://www.bps.org.uk
2. British Association of Counselling and Psychotherapy: 01455 883300

Thank you once again for participating in this study.

Appendix E: Interview Schedule

1. Can you say something about your development of 'countertransference awareness'?

2. Can you say something about whether or not the development of countertransference awareness influences the therapeutic relationship?

3. Can you tell me about a client you worked with prior to the development of your CT awareness?

4. Can you tell me about a client you worked with following the development of your CT awareness?

5. Is there anything else you would like to add?

Additional Question added:

6. What might be easy / difficult for therapists to talk about regarding their countertransference awareness?

Supervisor Questions:

7. Can you say something about SUPERVISEES developing 'countertransference awareness'?

8. What might be easy / difficult for supervisees to talk about regarding their countertransference awareness? Do you have some examples?

9. Can you say something about CT in the supervisory relationship? If any what affect do you think this may have?

10. Can you say something about your **development** of CTA? Has your developing awareness influenced your SUPERVISORY/ therapeutic relationships in any way?

11. Prior to this development did your previous lack of awareness influence your therapeutic relationships in any way? [Client examples if no supervisory examples]

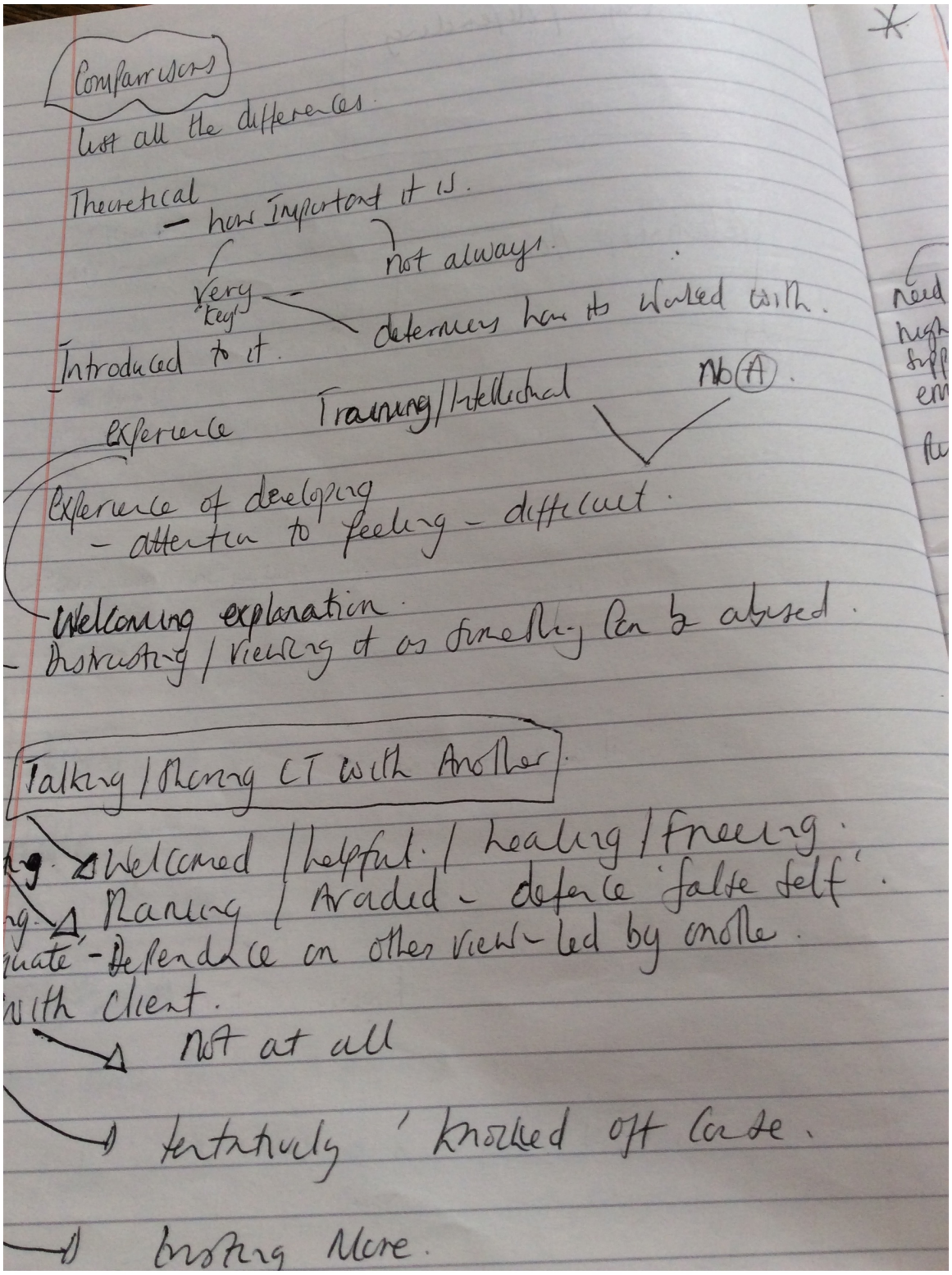
12. Given this development would you now do anything with a client/SUPERVISEE differently? Examples

13. Is there anything else you would like to say/add? Are you left with any questions about this issue yourself?

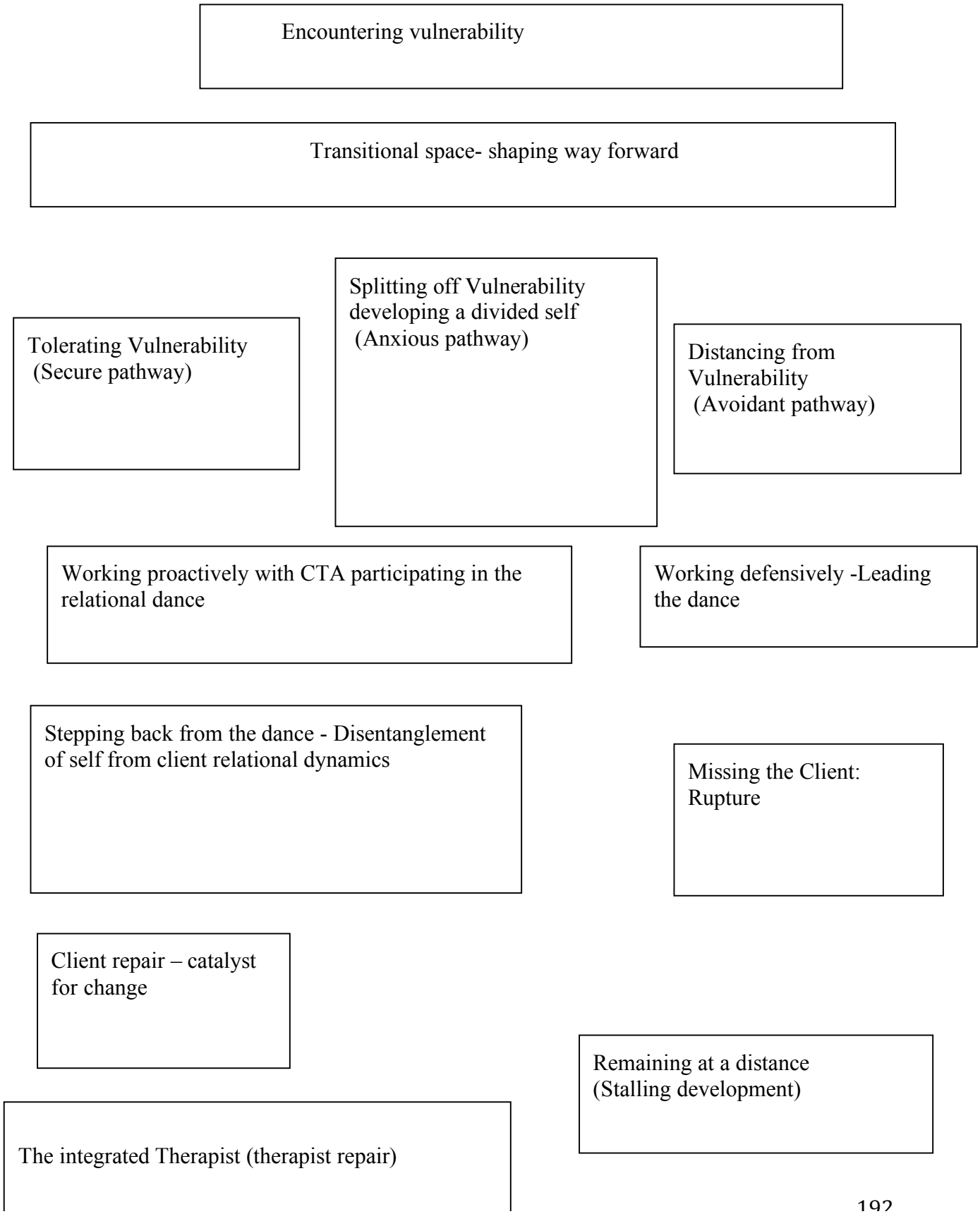
Appendix F: Excel Table Constant Comparison

Category: Working defensively
Controlling
P2 Focusing on managing the client prior to developing CTA
P1 Having own agenda needing to help the client move on
P1 Hiding feelings from clients needing to keep composure
P2 Needing to be prepared and have a focus for the work and missing the client in the process
P2 Having own agenda not listening to what the client needs
P2 Wanting/needing to be in control of self [feeling, thinking and responding]
P4 Holding preconceptions about certain types of clients and finding it challenging when they don't match up
Self-focus
P7 Focusing on self and not the clients experience of the relationship
P6 Dismissing the client's communication seeing it as irrelevant
P2 Focusing on own response not reflecting on the affect on the client
P2 Changing behaviour without an explanation being given to the client
P4 (Early on) viewing self as a separate from the client – not considering own responses had anything to do with the client
P4 Seeing self as too clever being dismissive of bodily responses
P7 Needing to advocate for the clients coming from proactive CT
P8 Being aware a need to rescue clients
P8 Having a self-focus early on making sense of feelings separate from the client
P5 Focusing solely on self not reflecting on the clients experience
P8 Worrying about the experience revealing something about self that was wrong 'being under the spot light'
P8 Wrestling with CT early on due to self-judgment
Editing
P4 Needing to present the self as a competent therapist by editing what is shared
P4 Only taking clients to supervisor which show self in a good light
P7 Not wanting to share with the other supervisee and finding this difficult
P7 Finding easier to discuss theoretical issues in supervision than client / own material
P7 Feeling troubled by CT and not having anywhere to talk about
P7 Finding it shameful to share all of self in joint supervision
P7 Experiencing the colleague as also editing her material
P7 Experiencing a change in atmosphere when bringing self to supervision
P8 Needing to be liked by clients keeping the relationship nice

Appendix G: Memo Example



Appendix H: Example of Earlier Diagram



Appendix I: Participants replies member checks

Yes, this does capture my process. It was a long time ago but I think I can remember [P9]

Yes- this diagram is quite a comprehensive and accurate schematic of process for me. I was wondering if you would be able to send me a printed copy of it? I think it could be quite valuable to have [P10]

I really liked the diagram - In brief, it reminded me of the downward spiral or virtuous cycle. I could see myself in every box! [P7]

I have checked the diagram, no issues from me. [P2]

Appendix J. Project certificate Information regarding chosen journal

Journal article to be submitted to ***Psychology and Psychotherapy: Theory, Research and Practice. Published by the British Psychological Society***.

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments.

Journal publication guidelines:

- Word limit for qualitative papers: 6000 words. The word limit does not include the abstract, reference list, figures and tables. Appendices however are included in the word limit.
- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details.
- Tables should be typed in double spacing, each on a separate page with a self- explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use.
- All Articles must include Practitioner Points – these are 2-4 bullet points, in addition to the abstract, with the heading ‘Practitioner Points’. These should briefly and clearly outline the relevance of your research to professional practice.
- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete..

  This journal was chosen to submit to because it is a British Psychological Society Journal and is likely to be read by the target audience of Counselling Psychologist’s

Appendix K: Extract of transcript

Extract from transcribed interview with open and focused coding

Transcript	Open Coding	Focused Coding
Perhaps if you could start by saying something about your development of CT awareness?		
Ok Um, in terms of my understanding of what it is or my own kind of of understanding?	Checking out the question	
Yes what is your understanding		
Um gosh I guess (pause) it would have been back when I did my counselling foundation year we would of touched on it but I don't remember it that much I think I have always found it a little bit confusing, all the different concepts slightly so I guess it's	Reflecting Positioning start of understanding Describing it as brief Difficulty remembering Finding it a thing that is confusing Understanding it as having different concepts Remembering when developed an	Finding it hard to remember (conceptualise?) development of CT awareness

probably from the counselling year I would imagine and when I did my when I worked as a graduate mental health worker and I had a psychodynamic therapist as a supervisor which was a real contrast as were doing CBT and person centered and she didn't really know that much about CBT but that probably influenced me to go on and become where I am today. But she was a real kind of always about the process and did it feel being with the client what was that like for you and she kind of really, I used to come out of supervision with her and have like a real bad headache because it was the first time I'd had clinical supervision and she was really intense but amazing you know she was someone I think of very highly and everything but it was the fact that she would be like what do you	understanding Describing training Having a psychodynamic supervisor Viewing the supervisor as contrasting with the therapy approach (CBT) Finding the supervisor didn't know much about the therapy approach Being influenced by supervisor Seeing it integral to development now Remembering her being focused on the process Focusing on how it felt to be with a client Finding it overwhelming Experiencing supervision for the first time Having nothing to compare it to Experiencing the supervisor as intense Experiencing the supervisor as amazing	 Finding CT a confusing concept Locating development of CT awareness with psychodynamic supervisor Reflecting on supervisor's focus on the process Being influenced by another (supervisor) Focusing on own process in supervision and finding it overwhelming

feel like in the room and I would be like I don't know. You know what mean because it would be kind of something I wouldn't think about because I went to the, when I was a graduate mental health worker we went on training to become the graduate mental health worker and that was based on person centered and CBT so we were very much about learning the generic type CBT stuff but it wasn't doing protocols because it was before then and then person centered was thinking a bit about what's going relationally for them but not so much about us and then suddenly I went to have supervision with someone where it was all about what we were thinking about in the room, what we were feeling and where did we notice it in our bodies and stuff and that to me was quite alien to	Thinking highly of the supervisor Finding her approach challenging Experiencing not knowing Being made aware of things normally wouldn't think about Finding her approach was different to experience of being a mental health worker / training Describing different approaches Seeing learning as generic CBT Viewing the CBT as different Viewing the CBT as something else – person centered Not focusing on self/therapist in the relationship Comparing with supervision Finding supervision was also about therapist in the	Struggling to consider CT responses Developing a two person approach to the work Becoming more self aware through supervision Moving from focus on client to focus on self and finding this alien

me at first which was probably why I came away with quite a headache. She would always ask me questions that I hadn't thought about, hadn't asked the clients, so I kind of of thought of thought am I doing something wrong here and she wouldn't necessarily direct me, it was just by the questions she would ask and you would go away and think about things more. So I think over a period of time my awareness built up more into thinking about my responses and my physical feelings, my emotions and everything that went on with a client and how that kind of might impact my history, things that I have learnt over my childhood and slightly different things and so I know then, so when I was working with this one client who was like um really like charming and would engage in a very flirtatious way	relationship Having to think about feelings Having to think about somatic responses Finding this approach as alien Seeing this as reason had a physical response of a headache Being asked questions Not feeling prepared for the questions Worrying about getting it wrong Having new information brought into awareness Becoming aware of gaps in knowledge Seeing her approach as non-directive Understanding the questions being asked as key Going away and reflecting on them Experiencing a growing awareness over time Expanding knowledge Considering self as therapist / responses including physical Considering the relationship with the client Considering own history in the	Developing awareness of self and responses Considering self unprofessional - feeling bad about own responses to the client Feeling embarrassed about taking these responses to supervision but trusting the process Finding supervision helpful in making sense of responses – feeling surprised by this Beginning to make sense of CT enactments

and at the time I was going through a break up my long-term relationship and um so I felt pulled to him and I felt really bad, I thought I'm being really unprofessional, you know having some kind of feelings for someone and I took it to supervision and I'm very trusting of supervision I think I always have been and my um I've got a colleague we also trained together so its group supervision and I was really embarrassed to take it there but at the same time I that I had to, because I was feeling really bad about it and um in actual fact not that I'm surprised they dealt with it amazingly you know, she kind of asked me about what was going on for me and kind of linking it to things which were going on outside of my life and she just kind of you know the way we talked	relationship / learnt in childhood Considering different things Feeling more prepared Reflecting on this in practice Finding a client charming Being flirted with by a client Experiencing a relationship break-up in personal life Feeling pulled in my client Feeling bad Feeling unprofessional Having feelings for a client Taking feelings to supervision Feeling trusting of supervisor Feeling this has always been the case Having a familiar colleague from training in the group supervision Feeling embarrassed to talk about having feelings towards a client	Building understanding / awareness through self-reflection Orienting self by focusing on own responses Developing a meaning making strategy towards own responses Noticing the affect CT

about it was more kind of understanding and the more I understood what was going on the more it was ok that makes sense now because I got this break up going therefore I'm feeling quite vulnerable and I've got someone whose charming, whose being quite flirtatious, actually who is being quite avoidant as he didn't want work on what he needed to work on so he would engage me in this kind of in this way and so by actually talking about it and kind of understanding what was going on it could I could then change, I could see it in a different way. I didn't feel embarrassed as I understood it and I didn't feel like I was being unprofessional because I kind of of got into that trap so then the next time I saw him I kind of just changed the way I was and I didn't go down that line of being	Believing had not choice but to take it to supervision Feeling bad about having feelings for a client Being surprised with how the group dealt with it Considering what was going on in personal life Having response linked to own life Finding supervisor understanding Finding this helped develop own understanding Having an explanation which made sense Connecting own feelings to own relationship break up Viewing self as vulnerable Feeling vulnerable with a charming man Being flirted with when feeling vulnerable Understanding he was being avoidant Finding the client was avoiding his own stuff Being engaged in a	had on self Changing behaviour without explanation being given to the client Comparing –using CT experience to inform the client work Developing curiosity about the meaning of own responses Feeling the clients unconscious communication of anxiety Moving into a different way of working wanting to unravel and unpick own responses to inform the client work

flirtatious and he was kind of of oh this is different today and he didn't like it because he like that avoidance. It was the first time I really noticed how it could affect me and so that built my awareness more than ever really. I think over the years and certainly thinking about the questions today I definitely like to get a sense of how I'm feeling in the room with the client and that tells me a lot and when I don't have that I feel quite lost because some people will come in and I will be getting really anxious when I'm assessing them and I think well I've done this hundreds of times and why am I being anxious and I realise it's not me their maybe projecting on me which I know isn't really necessarily CT but it's all gives a sense of what's going on. So for me anytime that I have I would	flirtatious way by the client Talking about it with others guiding understanding Viewing it in a different way Being able to change Moving away from feeling uncomfortable about it through a new understanding Developing a new perspective No longer feeling unprofessional Seeing it as a trap Changing approach with the client Moving way from a flirtatious response Viewing client as aware of the change Finding the client didn't like the shift Understanding his feelings about avoidance Experiencing how it affected self for the first time Using this to build awareness more Seeing this as changing over time Looking back Thinking about the questions Being aware of own feelings in the room Finding this a source	Questioning negative responses to the client taking the time to reflect Being aware not to respond to negative emotional responses waiting to know more

say the stage that I'm at now anytime that I have an emotional reaction to someone I want to try and understand it and unravel it and unpick it then maybe perhaps to know what those things are and how I can work with it and I would probably say that's probably the stage that I'm at now I would say um I don't think I'm thinking of someone that I might actually present who she said something which I um think she's got quite Asperger's but at the time I didn't realise it it was the second time I saw her and she said she would like to get a weekend job so she's not with her children because she just wanted to get out of the house and leave them and I was god that's weird you know my immediate reaction is to kind of of I don't understand that I don't get that having a young son myself	of information Not feeling so lost Feeling anxious with clients Reflecting on the feeling Looking at the context the feeling has arrived Realizing the feeling doesn't fit Viewing it as being projected by the client Thinking this isn't CT Finding the experience informs what is going on Viewing self at different stage now Reflecting on emotional reactions to people/clients Needing to unpick/unravel/understand Viewing it as containing important information Seeing it as informing how to work with the client Considering this as stage at now in clinical work Reflecting on a client	Sitting with not knowing Wanting to fully understand the client and viewing this as lessening the likelihood of reacting Focusing on the clients experience rather than own

and I was like I want spend all my time with him so you know lots of negative reactions in me and at the same time I was thinking I don't know anything about why she's saying that so I need to understand it more before I go along this kind of I don't like you do you see what I mean just respond against her in someway so I can tell that I've already got to that point where actually just wanna the more I understand about her situation the more, the less reaction I will have and think about how I would bring up my children in comparison to how she was. So I think it's really helped me actually its really enabled me to progress and it's a huge part of the therapy process	Considering the client pathology Viewing the clients experience as weird Not understanding the clients experience Comparing to own experience of being a mother Viewing own experience as different Viewing own experience as the right way to be Having a negative response to the client Feeling confused to why the client would feel this way Wanting to understand it more Not liking the client Having a negative response to a client Considering their s more going on Understanding it will become clearer the more I know Believing this will lessen the response Comparing own life with clients Viewing CT awareness as helping Viewing CT	

	awareness as enabling development Viewing CT as a huge part of the therapy process.	
Prompt: you seem to be saying that it wasn't your training it was the supervision which first seemed to develop your awareness, could you say a little bit more about that?		
I guess because the training was a group setting so you might do role plays, in supervision it was me and my colleague and it was very much based on quite specific kind of questions directed towards me about how I felt about being in sessions with clients and it was those kind of introspective questions that got me to think about it. Where as I guess when it's in a teaching room you kind of don't you might think about it but	Describing supervision Being part of a group Doing role plays with colleagues Seeing it as being specific Having questions directed about own feelings with clients Viewing those questions as introspective Finding them helpful to enabling more reflecting Finding this different from being in a teaching room	Developing introspection through supervision Feeling under pressure to come up with the answers Moving from theory to developing own

when your perhaps in a smaller group in supervision your kind of of expected to come up with some kind of answer well I felt like I was expected to come up with answers then I think about it more I'm thing she's going to keep asking me and she did so therefore I kind of of needed to be aware so I guess that kind of made me think about it in that way and certainly after having the experience with the guy who was quite charming then it made me take a whole new picture on it and how you can get pulled in and that could go kind of colluding with the client and then not helpful for them so I think um I think supervision was defiantly the best thing really and I don't know whether I would of got there without having her as my supervisor I'm quite lucky really I	Expiring greater expectations in a smaller supervision group Feeling pressure to come with an answer Considering this may be own experience Being able to think about it more Being aware that supervisor will ask questions Needing to be aware because of questions Having to think about it in a certain way Relating this to the own experience of CT responses Viewing CT awareness as offering a different picture Becoming aware of being pulled in my clients Becoming aware of colluding with clients Understanding that this isn't helpful for clients Viewing supervision as the most significant thing in the development of this awareness Thinking would not	understanding Furthering CT understanding by brining client work to supervision Moving away from reenacting / being pulled in but now aware of how to use it to develop clients understanding Feeling unsure whether CT awareness would have developed without having the right supervisor Valuing the opportunity to develop CT

trained in London and we were working originally for a PCT but they couldn't manage us because they didn't really have the resources but they had the money so we got seconded to MIND which was a very small organisation in London and the manager there just had a contact had heard of someone who was quite good and contacted my supervisor whereas I think fi we were supervised by the PCT we would of got someone else probably a CBT person I might have had a different experience so I do kind of appreciative the fact that because I have a different number of supervisors since her I appreciative that she gave me such a holistic kind of way of looking at people and I think that's probably why even though I'm a CBT therapist I've always been	have got there without a CT aware supervisor Viewing self as lucky Reflecting on training Reflecting on limitations of PCT resources Having to find a supervisor outside the PCT Seeing this as good thing Comparing what it would have been like with a PCT supervisor Having a CBT supervisor Viewing a CBT supervisor as different Viewing experience of supervision as being different Feeling appreciative that this didn't happen Feeling thankful had CT aware supervisor Viewing the CT supervisor as offering something more Developing a more holistic way of	awareness Viewing own development as an on-going process feeling happy about this

quite integrative in away and it's kind of developing more and more because I feel that's where I want to be really	looking at people Describing self as a CBT therapist Viewing self as integrative in a way despite being a CBT therapist Seeing this preferred model of therapy Wanting to develop as an integrative therapist	
I wonder if you could say a bit more about your CT awareness and whether this influenced the therapeutic relationship with your clients?		
Um I think in terms of that client because she actually said people think I'm weird and she was aware people might have a negative response to her so I guess she was probably looking if I had a negative response to her and without being aware about the CT and my own feelings and realizing I didn't really understand the	Working with a client Client positing herself as weird Client being aware of peoples negative responses to her Viewing the client as looking to see if she was getting an negative response Being unaware of CT and own feelings Realizing didn't understand the client	Responding to the clients expectation being pulled in Putting feelings aside needing to know more

whole basis of what she just said meant that I could then part, I could kind of think oh that's not really very nice but put it out of my mind put it out of the way and think I don't actually know everything that's going on and as I actually need to know a bit more everything kind of stopped into space and it makes complete sense so I think actually having that awareness made our relationship, I think there would of probably been ruptures or minor little ruptures throughout whereas I think our relationship was actually quite good someone I only saw monthly so it was quite hard. I think with a lot of clients its quite hard to keep up that rapport with when you only see them monthly but I think that she didn't come in because her husband wasn't around as much and she	Not viewing the client as very nice Putting it out of mind Putting it out of the way Not knowing what was going on with the client Needing to know more Finding everything stopped Becoming aware Viewing this a making sense Viewing CT awareness as struggling the relationship Viewing it as avoiding ruptures / Minor ruptures throughout Viewing the relationship as quite good Viewing the relationship as hard due to gap between sessions	Needing space and time to understand the client

only wanted her husband to look after her kids when she came in so therefore she only came in once a month but it didn't feel like we were going over stuff and catching up it felt like they were manageable so it didn't affect our therapeutic relationship so that in a way it helped that I was able to make space and understand what she was saying in a different way	Viewing long gaps as having an impact on rapport Finding it different affect the therapeutic process Finding the gap didn't affect the relationship Viewing the gap in session as helpful Needing space to consider the client in a different way Needing more time to reflect on relationship with the client	
Could you say a bit more generally about CT awareness and the therapeutic relationship?		
Um I guess I think about my awareness in the therapeutic relationship in terms of CT I think it's just um (pause) I thinks it's really imperative kind of of understanding and being able to sit with someone and I don't really	Considering CT awareness in the therapeutic relationship Viewing it as imperative Viewing as kind of aiding understanding Viewing as essential in building the relationship Believing it wouldn't	Developing the ability to sit with someone through CTA

know how I could do it how I could build a therapeutic relationship without having that awareness really because I think there would always be something that was quite void in someway or missing and I think it's like there are times when I don't get a sense of someone I'm always really aware that there is something missing so for me it kind of acts as like the glue almost to everything it kind of connects up because even fi you've got kind of a relatively clear formulation you don't get a sense of who they are if there's no kind of feeling there it kind of feels a bit empty your kind of going down the lines but your not really sure and that can have an impact on the therapeutic relationship because you don't, I don't feel you can go through the process of trying to help them but there's no	be possible to build a relationship without awareness Considering there would be a void or something missing Finding there are times Getting a sense of someone Finding there is something missing Viewing it as acting as the glue to almost everything Viewing it as connecting up Having a formulation Seeing is as missing information Missing a sense of someone Having to feeling Finding it feels empty Doing it but feeling unsure Experiencing it as impacting on the relationship Needing to feel in the relationship Finding it is a barrier to helping	Using CTA to make connections, (with client and within client's material) Working in the dark missing important parts of the client Building an alliance by knowing where the client is coming from through CTA

substance there so I'm never quite sure if I'm doing things the right way and then I think perhaps the alliance isn't as strong whereas I think someone where you kind of really know were their coming from you get a sense of them you kind of know you kind of get, I always feel it's like a team your working together and I think if that isn't there a feeling about what's going on the CT then you don't know if that's definitely the right thing and so I would ways be like oh maybe it is maybe it's not, maybe we try this maybe we try that and I guess in the therapeutic relationship it doesn't come across as confident and you know like I said the glue isn't there	Going through the motions Viewing the relationship as having no substance Feeling unsure of doing it right Having weakened alliance Comparing with someone you do have a sense of Knowing where they are coming from Viewing is a collaborative working as a team Not knowing what's going on with the CT Not knowing it it's the right thing Feeling unsure Trying different things Coming across as lacking in confidence in the therapeutic relationship Finding the relationship/glue isn't there	
Could you say a bit more?		
It gives me add information and if I didn't have that then yeah it just	Getting information from CT Not having information	Viewing CT as essential information

um, it's weird there can be other parts to the formulation missing but if I don't have that then I feel all of the other stuff is just words and nothing attached to them as much and that's when I tend to get to which is response to your last question, is when I tend to get into the doing part of the therapy therefore the therapeutic relationship might be ok it might not but it's all about the doing it then misses out on the other more important things but then I've got nothing to attach it to	Feeling weird Finding parts of the formulation missing Needing to having a complete formulation Viewing the formulation as just words Viewing it as lacking something Needing to get to Thinking have already answered this question Being pulled into doing therapy Not knowing how the relationship is Viewing doing therapy as missing out on more important things Having noting to attach to	Feeling lost without CT moving into doing Missing out on important elements of the clients world
Ok do you want to talk about your two clients now? Shall we look at your client where you had not developed CT awareness yet?		
Well I worked with someone do you mean when I didn't have?	Clarifying the question	
Yeah before you had developed your CT awareness?		

Um well it was probably someone I worked with she came into the service she was experiencing depression and anxiety she was a lady she was retired she looked after her mum but not all the time she lived on her own she had three daughters all living away from home, one relative near with a grandchild, and um she basically came to therapy because her relationships she got depressed basically because her relationships, her close relationships weren't really working but and she was also someone who wanted to do lots and lots but didn't manage to do as much as she wanted, as she had a perfectionist type thing. She kind of recognised that maybe there was relationships in her life that maybe she had affected the relationships in her life but she	Describing the client Viewing the client as experiencing depression and anxiety Describing the clients background Coming to therapy because of relationships Finding the client had clear goals for	Working with a client with clear goals

couldn't really work out why or how. She was also incredibly religious so she would spend a lot of time doing a lot of bible reading and really helping out other people. But she was a lady who would come into sessions say this is what I want to work on, she would be quite, reasonable clear, you know it was things around setting out because she was it was kind of setting out things that she could, how she could manage her life better as she tended to do too much basically. So she wanted to do less but equally she wanted to change her relationships but she didn't really want to work on the relationships either so she was someone where you would be getting into the course of doing therapy with her but she was very argumentative not argumentative but talk around	therapy Viewing the client as clear with her goals Finding the client unclear about what she wanted to work on Getting into the course of therapy Finding the client was being argumentative Viewing the client as not argumentative Being told the therapy is helpful Experiencing the client as not finding the therapy as helpful Being challenged by the client Viewing the client as difficult To work with Needing to explain why Locating the time	Finding it hard to deal with being challenged by the client

how she could do something that would be helpful but then she would try justify why that wouldn't be helpful, she would kind of challenge everything that was said she she was um a really difficult person to work with. She was someone who I would say it was alter than the person who I had seen the guy I spoke about the charming guy because this was when I was training to do my CBT in IAPT and she was one of my CBT cases, my accredited cases that I put through so I was trying to follow the depression model which was incredibly hard and I had, my supervisor was great but she was very CBT, so therefore thinking outside of it in terms of CT my head wasn't really, you know that wasn't the place I was in it was like she is my CBT depression case this is what I'm doing and	frame when saw the client Putting it in context of stage of training Working in a particular way Following a model Finding this hard Having a good CBT supervisor Not being able to think about CT Not feeling able to engage with the CT Finding not in the right place to think about CT as didn't fit with model Having to think about the client in a different way Doing what your suppose to do Finding the client hard to manage in the sessions Focusing on the main problem summarizing with the client viewing the client as rambling trying to summarise	Focusing on managing the client prior to developing CTA

that's how your suppose to think. So she was someone who was coming in and she was really quite hard to manage in the session and I she was someone that I one of the main things I had with her was I used summarise with her as she would ramble on for ages and I would try and summarise and she would be going like no and I would be like ok and she kept doing this you know every single time and then she would end up after she had said no, she would ended up rambling for a little bit and then getting back to what I had said and basically saying that's it and then when I summarized to see if that's what she was saying at the end, she was like no. This went on for a number of session really and my supervisor again she was don't focus on the therapeutic relationship because that's not	getting it wrong finding this repetitive continuing to struggle with understanding what the client was communicating Continuing to get it wrong Continuing for a number of sessions Being told not to focus on the therapeutic relationship by supervisor Being told this isn't what needs to be done Being told to focus on the CBT/Depression Finding that this wasn't helpful Going round in circles Not knowing how to engage the client Not knowing what to do differently Listening to tapes in supervision Coming up with a plan	Focusing on content rather than process Being led by the supervisor / model and not the client – being told not to focus on the relationship and focus on the symptoms and model instead Labeling the client from a distance Blaming the client - Projecting own struggles and helplessness on the client Being caught in a power struggle Avoiding the process and focusing on strategies and techniques (thinking rather than being?)

what were going to do were just going to focus on the CBT and the depression but she was but to be honest we weren't getting anywhere we were going round and round in circles, I didn't really know how to gage it or do anything differently and so in the end my supervisor ended up listening to lots of tapes, we listened to about 3 and we came up with the plan of not summarizing and saying only very short snippets because my sense of the client was that she was a bit narcissistic and she wanted to know before I was trying to tell her, or summarise, even though she knew it she didn't like the fact that I could do it in bite size chunks.	Changing the approach Stopping the summarizing Keeping it brief Viewing the client as narcissistic Blaming the client Criticizing the client for wanting to be in control Understanding the client knew what she was being told Being able to discuss it better than the client Viewing the client as threatened by the therapy Owing this as own perception Getting it wrong Changing approach Affecting the relationship by changing approach Being aware of what was	Operating on an intellectual/defensive level Working hard and going nowhere Engaging in fruitless power struggle (engaging in dynamic without reflecting)